New Orleans Medical

and

Surgical Journal

Vol. 79 JUNE, 1927 No. 12

THE DIGNITY OF MEDICINE.*

HUBERT A. ROYSTER, M. D.

RALEIGH, N. C.

If I may bring to my hearers the genuine flavor of true medical science; if I can interpret for them its real meaning and portray its pure spirit, I shall be of all men most happy. For medicine is a dignified calling—dignified in the original sense, that of being worthy. It emerges the most exalted of sciences, as well as the most beneficent of arts, since its sole purpose is the relief of human suffering and the saving of human lives. Science, which is organized knowledge, is correlative, mutual, allied in all its branches. The science of medicine embraces all other forms of science, takes over what it will from them, applies it to its own humanitarian aim; it is universal, altruistic, sacrificial.

Not without struggle has medicine reached its present proud position. The combat has been largely ignorance, both within and without its own ranks. The art of medicine—the practical work of treating illness—existed before the dawn of history and even in 400 B. C. flourished as a learned profession under the leadership of Hippocrates, the "Father of Medicine." The science of medicine began with Louis Pasteur, the great Frenchman, who was not a physician, but a chemist. His discovery of the microbial origin of disease, brought eternal glory to his name and he remains the sublimest benefactor of all mankind. All through the ages the faithful men of medicine have stood for education, culture, refinement. The very title by which they are commonly designated—doctor—means teacher; and the physician who excels is performing the task of a teacher every day and every hour of his life.

How, then, account for the presence and persistence of quacks, impostors, irregulars, cultists and the like? Are our high ideals being flaunted? Have they been ground beneath our feet? It is a common experience that no matter how low the standards of any establishment may be, there always will be some endeavoring to enter who are not qualified. Once the bars are let down it is difficult to lift them again. The various "schools" and cults in medicine represent those who could not hope to reach the mark of the highest calling and therefore seek on a lower plane to create a separate system founded customarily upon one lone hypothesis; previously reviewed, perhaps, by medical scientists and either given up in favor of more progressive thought or still included as a part but not the whole of the truth. All the "pathies" have been organized under the guise of half-truths—or more properly quarter,— or sixteenth-truths,—as if they constituted within themselves the elements of a basic science, by attempting to subject the diagnosis and cure of all diseases to one narrow theory. All-embracing science finds no resting place with them.

*Address of Annual Orator, delivered before Louisiana State Medical Society, New Orleans, April 26, 1927.

The same has been true of other institutions, notably the Church. Religious denominations by scores have sprung up, and are still springing up, all over the world, each one being formed on a different interpretation of some one portion of revealed truth. Cutler expresses the view that "there are three parasites which have clung to each successive stage of civilization—quackery, drunkenness and prostitution. These parasites have maintained vigor, persistence and superiority over all the efforts of church, state and society; quackery, chiefly because of human gullibility." Quackery may not be placed in the category of crime, but its effects are sometimes worse than criminal, particularly in the reflex result upon the victim. Peculiar to *homo sapiens* is an innate feeling that he is versed in profound knowledge of that most delicately balanced mechanism, his own body, and yet a willingness to accept advice from the most ignorant of sources, especially if the advice is pleasing, agrees with his own ideas and is accompanied with claims of certain cure. Not all gullible people are of the lower order, uneducated or illiterate. Many of so-called culture are most easily influenced. It is charitable to say that their culture may be of the spurious type—a sort of culturine. And it might be through no fault of theirs; probably they were vaccinated for culture, but it failed to "take." At any rate let us not look for the existence of charlatans to any rational thought or consistent cause, but rather to a natural tendency of the human animal to go the easiest way, to be flattered by artful assurance. Those who know the least often promise the most. Real medical science, like real religion, will proceed to the end of time, vaunting not itself, but persuading man 'to know and reverence the truth and to believe that only so far as he knows and loves it, can he live worthily on earth, and vindicate the diginity of his spirit."

A queer phase of the lay mind toward the profession is the confident conception of medicine which the average man thinks he possesses and his constant readiness to give counsel to those about him. Years ago Beddoes observed: "There are three things which almost every person gives himself credit for understanding, whether he has taken any pains to make himself master of them or not. These are: 1. The art of mending a dull fire; 2. Politics; 3. Physic." It will be granted that each one of us knows he can fix a fire better than any other, and that political experts, replete with wise predictions, stand on every corner. It is equally exact that non-professional medical sages abound. Who has not seen the man (or woman) offering a sure remedy for rheumatism, suggesting a diet for reducing, or advising what operation should be done? And in each instance, of course, "your case is just like mine." Not only that, but our diagnoses are continually made for us both by individuals and the public—at times a very interesting if not helpful procedure. Moreover, prospective patients are often told what not to do, according to the counsellor's experience, and thereby a loop-hole of neglect is furnished. No other concern in life is so beset by advisory suggestions as that of medical practice. It seems monstrous that the average citizen should pretend to so much familiarity with the most abstruse of all sciences, whose workings are fraught with much possible danger to health and life, when he rarely essays to great conversance with less private and more simple affairs. Seldom does the outsider tell the grocer how to buy or sell his provisions; the minister what to believe or to preach about; the lawyer how to defend his client or what sort of a speech to make to the jury. It is quite true that each community is overflowing with would-be directors of all professions and all trades, and no individual or set of individuals is exempt from their strictures. But no other vocation is so intimate and personal as that of medicine and none so intricate or so perplexing in its applications. Mr. Kipling has expressed this very well: "They

(doctors) will always be exposed to the contempt of the gifted amateur, the gentleman who knows by intuition everything it has taken them years to learn. They always will be exposed to the attacks of those persons who consider their own undisciplined emotions more important than the world's."

The practicing physician has little or no social tranquillity. In any gathering he is rarely allowed to be himself, but perforce is fused with his profession and plied with all sorts of declarations and interrogations pertaining to his work. Hardly any doctor has escaped such questions as these: "How is the health of the city?" "Many sick people now?" "Do you think I ought to be vaccinated?" "What's the cause of appendicitis, anyway?" "Are we going to have another 'flu' epidemic?" The presumption seems to hold that the doctor of all men longs to descant upon his occupation and his patients, when usually the reverse is true. To our shame, however, it is only too evident that some physicians glory in "talking shop" and in expatiating volubly upon their "cases." The laity, unfortunately, may take their cue from such men, but they do not represent the high type. It is one thing to instruct, to enlighten individuals or collections of citizens, in private or in public, upon questions affecting their well-being and that of the community as a whole; it is quite another thing to answer untenable questions, to give unjustifiable information concerning personal matters or to attempt explanations of things impossible or irrelevant. Further, there is a natural interest which excites inquiry about those near and dear; and there is a spurious, sometimes forced, inquisitiveness, taking in wide territory, which is born of human wonder.

Cynical as it may sound, it is no exaggeration to say that much of so-called sympathy is merely curiosity. The testimony of those who know will be convincing. Almost any hospital officer and numbers of physicians can tell of countless requests from utter strangers for exact and familiar details respecting the illness or injury, not always of "certain people of importance," but frequently of persons unknown both to the inquirer and also to most of those about him. Nearly as common as these promiscuous petitions are the instance of anger and irritation on the part of those who are told that no information can be given them or who obtain only general expressions without the much desired, but properly withheld, particulars. It is a question, of course, how far those in charge of the sick may or may not go; on the one hand in preserving the privacy of the patient and his home, and on the other in giving the public the facts which should be known. In many instances the physician's judgment is taxed to the utmost by conflicting responsibilities. Without the shadow of hesitation his first consideration is the patient and the family. The man in the street and the woman in society often brook no opposition to their desires and cannot understand the close-mouthed medical man or the institutional official who will "tell you nothing." The curiosity complex worketh within them a greater amount of attention and a far more exceeding weight of security than would be exhibited by legitimate human sympathy. After all, the sympathy that serves is practical sympathy,—relief for the sufferer, lightening of his load, cure of his complaint. Not all the visitations, not all the proffered counsel, not all the well meant commisseration can assuage like the helpful hand and the knowing heart. In a group of men at a club a physician was asked by a very prominent member of the community what was the matter with Mr. So-and-So's wife who had recently been operated on. The questioner, who barely knew the patient and was no particular friend or connection of her husband, was virtually insulted when reminded that it was none of his business; but justly felt rebuked when the affair was brought home to him by asking how he would feel if the same question were put by another in re-

gard to his own wife. Truly there are conditions that cannot with propriety be revealed to the glaring gaze of the public, and medical confidence is one of them.

Let no one assume from this that medicine stands for concealment. In private matters the profession respects the trust reposed in it by patients and the public. Numberless are the confidences locked up in the bosoms of physicians; and, in behalf of our social order, Heaven is to be thanked they *are* locked up. But there should be nothing of the mystic about medicine. One of the very strongest stipulations in the Hippocratic oath is that no secrecy should pertain to the practice of the healing art, but that such knowledge should be passed on to others. These others, however, are to be bound also by the oaths in order that "the benefit of the patient" may always be kept inviolate. Whatever of incantations, of ritualism, of charms and amulets that remain from the darkest periods are due to superstition, credulity and untrained thinking. But the doctor, above all people, must keep an open mind. He must not erect an intolerant barrier that may keep out the light. As better said by Strachey, "though the doors must be shut against superstition, it must always stand open to discovery, and even if a little superstition temporarily creeps in through the aperture, that must never be made an excuse for creating the debilitating atmosphere of the closed room." The distinct trend of medical thought is toward the open spaces. The earnest intention of the progressive physician of the present day is to contribute his share of knowledge toward the prevention and alleviation of disease, to inform the public of what is to be done and how to do it, to explain and to simplify methods, so that they may reach the understanding of the people. Collectively medical men have combined forces in boards of health, hygienic associations, local and national societies to stamp out the very conditions from which they make a living, considering themselves rather apostles of prevention than ambassadors of sickness. Just as important as public health is individual health, and here the doctor finds his field as teacher. For, many of these important questions cannot be settled in the herd; they must be brought down to the particular person. To instruct him, to show him by precept and example the way to health; to cure him of his ailment in the simplest, straightest fashion; to tell him the truth as the truth is known—this is the clear purpose of the present day physician. He would welcome those who may grant him such privilege.

Two further features call for consideration—the layman who essays to be his own doctor and the physician who regards himself as his own patient. There is an old proverb—anonymous and variously quoted—which runs: "Every man at forty is a fool or his own physician." Like other aphorisms this one may mean much or little, according to its interpretation. The evident purpose of this proverb is to say that at the age of forty a man should have learned to take care of himself or else he is relegated to that class which is deficient in intelligence. Preventive medicine, the highest aim of the physician, should be comprehended by each man for himself during the twenty years after the age of maturity. Not to do this is to dub himself a fool. Testimony is not wanting to show that at the age of forty most men have attained the zenith of their individual power, both mental and physical. Scores of them do greater things after this period and many reach their full development earlier. Nevertheless, forty is the time at which most of them take earnest thought of what has gone before and arrange to press forward to whatever may be ahead. Some are wont to refer to the post-forty days as the "shady side." This, and perhaps the whole affair, depends upon the individual. Man has a truer measure of his own life as he rounds out the fortieth year and, at least, learns to know what he does not know. Young, in "Night

Thoughts," tells us: "At thirty man suspects himself a fool; knows it at forty and reforms his plan." This realization ought to be swift and sure, for we are warned by the same author ("Love of Fame") to

"Be wise with speed;
A fool at forty is a fool indeed."

At all ages it is meet for every one to understand that the way to health is by right living. The guide for the journey may be found in another epigram: "Know thyself." Nature makes a contract with each individual born on the earth. She says to one: You can do certain things without harm, without paying a big price. She says to another: You must pay me well for the privilege of living, you may not do certain things with impunity. Read the terms of your contract. The bonds mature at forty.

It is hardly necessary to say that knowledge of one's self and of the physical laws of the universe is not the only safeguard, since physicians themselves are sometimes notable offenders. It is, perhaps, unfair to hurl back at them to practice what they preach, to destroy the effect of good advice by criticism of the adviser. Compliance with the spirit of our proverb is a matter of the will rather than the intellect, of common sense rather than technical knowledge. Under this particular count, then, we need not press the ancient accusation that a doctor who is his own physician has a fool for a patient.

Just as ardently as I would have the laity conceive of the honor and dignity of our profession, so I would enjoin my colleagues to remember their obligations and to be mindful of their allegiance. No career is so high in its ideals and few require such preliminary training as that of medicine. The time, the labor, the money spent in its study surpasses that devoted to any other calling. And this is well; for the physician, if he be true to his traditional faith, and ready for the coming time, must needs be an educated man in the real sense; one who can observe, who can think, as well as one who can express himself, who can perform. My stand is with those who plead for the preservation of the humanities, that they may take their place along with the sciences in preparation for the medical career. For the physician is the greatest of all humanists. His absorbing interest is in human nature, in human beings, in human life. Whatever contributes to these ends are needful for his consummation. The arts, languages, philosophy bring their recompense to those who would lead, who would understand, who would adorn their lives. The day of the accomplished physician is returning. We are beginning to live down the situation which will permit an astute layman to remark, as one did recently of a very distinguished physician, that "outside of his specialty he is an eight-year old child."

But let there be on this account no abatement of science. Rather give us more and more, for that way lies truth and progress. It cannot be insisted too strongly that medicine, in principle and practice, is a forward-looking affair. Science bids us be discontented unless we endeavor to learn something today that we knew not yesterday and, further, to discard the old if the new is better. This is the slogan of modern medicine. We have come through the time when Bacon spoke of medicine as "a science which hath been more professed than laboured, and yet more laboured than advanced; the labour having been, in my judgment, rather in circle than in progression." The advances since that day have been the part of natural science. When medicine appropriated from other scientific fields whatever might add to its own enlightenment, from that moment it became the most progressive of the so-called learned professions. Medical science has advanced so rapidly as to be of necessity almost entirely rewritten every twenty years. As pointed out by G. K. Dickinson: "Should Henry Ward Beecher come back to

his pulpit, he would find his preachment just as understandable and effective as in his day. Should Chief Justice Marshall return to his bench, he would find the law unchanged and his decisions acceptable. But should the most competent physician or surgeon of fifty years ago return, he would be at a loss, for the physician would be obliged to study medicine over again, and the surgeon would not be able to do the ordinary work required in the operating room." Thus, progress is justified of its believers. When science is joined to the humanities, when the ancient and honorable partnership of knowledge and culture shall be revived, then will appear the ideal man of medicine.

There is dire need in this time for the scientific mind. The educated physician should be sincerely grateful for the broad horizon which his training has conferred upon him. To what useful purposes his talents may be put, if only he will strive in private and in public to uphold the standards of his profession and to see that the people are enlightened concerning its aims and its ideals! A crusade for mutual understanding between physicians and laymen is most desirable. Whether this be carried on individually or collectively is a matter of taste and judgment; both methods are commendable. What is chiefly to be wished for is the instillation of the essence of science into the consciences of our public men, our men of affairs. To bring this about it is not necessary for physicians to engage in politics, but for statesmen to become imbued with the scientific spirit. Without it there is no actual appreciation of human problems. This is a legitimate opportunity for the education of the public, and especially of those who represent the people. Those in the profession who would prostitute their principles for personal or political exploitation, who see no reward in the promotion of science for its own sake, are not honorable ornaments of their profession nor worthy fellows of the guild.

Much discussion is heard nowadays in medical circles concerning campaigns of publicity and programs for advertising. Different ideas have been suggested, various means proposed and every known channel of notification offered to carry medical information to the people. There can be no warranted objection to any desire to educate the public concerning their health, to take to them knowledge about disease and to instruct them in the ways of getting well and keeping well. Beyond these limits it will require much righteous discrimination to determine how far to go; for with a smattering of learning and an undeveloped judgment the public may be hurt rather than helped. What appeals to my earnest conviction is teaching people in the clearest manner possible the fundamentals underlying health and disease, methods of preventing sickness, and the necessity of periodic physical examinations. Other problems will take care of themselves.

What would not appeal to me is a scheme of advertising which would include offering wares to the public, of having anything for sale, of holding out infallible cures of disease, of making promises or of effecting guarantees. The word advertise carries with it, whether justifiably or not, an implication of "puffing" one's self, of drawing attention to professed superiority, of seeking to proclaim to the public what should be known in other ways. I am aware that there are proper means for ability to be recognized—chiefly by what can be done, not by what can be said. When Shakespeare makes the King say, "we are advertised by our loving friends," he indicated a decent practice, but undoubtedly used the expression in a different sense from its present day significance. He was simply saying that we are "turned to" by our loving friends—a voluntary action and much more satisfying. By no twist of circumstances am I willing that my profession should be placed on a level with a commercial trade; I refuse to have it degraded to

the station of a "go-getter" or transformed into a boosting bureau; I will not be a party to any plan of cheapening the relation of patient and physician; I cannot subscribe to any proposal of aggrandizement, of boasting, of egoistic promises. Our creed should be: the widest publicity possible for disseminating information to the people for their instruction and for their well-being, but not for one instant the promulgation of self-seeking notoriety or the announcement of individual solicitation for business.

The high regard which many of the world's eminent men have held for the profession of medicine should not give us the feeling of the braggart or the sense of smug satisfaction. Cure for these complaints may be found in reviewing an equal, if not a greater, number of unfavorable opinions. Rather ought we to be thankful for those who perceive, who value the things we most revere and are willing and able to put them into words. Rarely have I seen so vivid an appreciation of the medical life as in the following tribute by John St. Loe Strachey: "I say, without the slightest fear that I may be overstating my case, that there is no profession which is more exposed to the temptation to forget honor, humanity and kindliness than the medical profession, and none in which the exploitation of human suffering is easier. *Yet there is none in which the temptation is so triumphantly withstood.* Let this be remembered by the public when they feel inclined to sneer at medical etiquette, and to speak of it as if it were a code for maintaining selfishness and enrichment. Medical etiquette is the salvation of the patient. It is the one thing which stands between him and the dangers of exploitation. It is what make him and his suffering hold the dominant part in the dread dramas of pathology."

A critique by Heywood Broun, the columnist, is not without its discernment:

"In the long run the heretics or reformers, call them what you will, return to the hospitable arms of mother medicine. Here's to the doctors; God bless them, almost every one. Dumb? Oh, yes, very often. Bigoted? Well, I'd not contend that they were free of bigotry. Reactionary? No, that I'll not admit. Sometimes the vast majority of organized practitioners seem set and sealed against well demonstrated innovation, but in the long run truth does prevail. No medically protestant group has long endured. * * * Among all the orthodoxies of the world, medicine alone has kept its apostolic line unbroken by permanent and serious secession. Much has been done by men who were outside the fold. Medical martyrs are numerous. The regulars have persecuted and slain their scores of saints in every age. But in the course of time they have never failed to canonize them. Medical justice may be slow-footed, but it grinds finer than the mills of any other profession."

All are familiar with this generous acknowledgement from Robert Louis Stevenson:

"'There are men and classes of men that stand above the common herd! * * * the physician almost as a rule. He is the flower (such as it is) of our civilization; and when that stage of man is done with, and only remembered to be marveled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and, what are more important, Heraclean cheerfulness and courage. So it is that he brings air and cheer into the sick room, and often enough, though not so often as he wishes, brings healing."

My object has been to present the profession of medicine as a dignified vocation, worthy of worship by its devotees, deserving the respect of those who need its

ministrations. I have not meant to confuse dignity with solemnity; for this profession of ours is a joyous, buoyant, hopeful occupation—entrancing in its study, alluring in the surprises of its practice. It demands courage and patience and endurance and an abundant amount of enthusiasm, but it furnishes a continuous occasion for all manner of things to know, people to help, lives to save. There are keen disappointments—yes; and bitter regrets and painful misunderstandings. And yet these are somehow swallowed upon in contemplation of the lofty aims and sacred aspirations engendered in all who are touched by the beneficient influence of the medical spirit. To perform some part in holding fast to our ideals, to aid in restoring the old-time confidence, respect, and faith between the profession and the public, to stimulate loyalty to all we hold dear, is enough to mitigate a life time of worry. Here at once is our challenge and our goal, a prediction by the French philosopher, Descartes, in the seventeenth century: "If ever the human race is raised to its highest practical level, intellectually, morally and physically, the science of medicine will perform that service."

SOME PHASES OF CRIMINAL ABORTION.*

E. A. FICKLEN, M. D.,

NEW ORLEANS.

The purpose of this paper is not to attempt to offer any solution to the problem of criminal abortion, but rather to comment on some of its phases from an academic standpoint. The total abolition of the practice is as little to be hoped for as the absolute suppression of homicide. Laws and discussions directed against the manifestations of the basic human passions are mandatory rather than punitive in action.

The writer wishes it to be understood that he is not advocating birth control, and that the brief discussion of that doctrine is unavoidable. The war between moral theology and expediency is destined to continue for many years to come, with the final decision in the hands of the individual. This essay concedes the futility of further argument.

Abortion is defined as the expulsion of the product of conception before twenty-six weeks gestation or viability. Criminal abortion is the bringing about, for an improper purpose, of the expulsion of the ovum before it is viable. The legal definition emphasizes the fact that the intent constitutes the essential element of the offense and is held to be equally guilty with the actual accomplishment. The ancient common law writers made no mention of abortion, though there are numerous references to it—both favorable and unfavorable—in the non-legal literature before the Christian era. "The question of criminal abortion," says Lecky, "has been considerably affected by physiological speculation as to the time when the fetus acquires the nature and therefore the rights of a separate individual—the general opinion among the ancient was that it was but a part of the mother and that she had the same right to destroy it as to cauterize a tumor upon her body. Plato and Aristotle both admitted the practice. The Roman law contained no enactment against abortion until the time of Ulpius. The Stoics thought that the infant received its soul when respiration began. The Justinian code fixed animation at forty days after conception. * * Aristotle even went so far as to advocate the enforcement of abortion by law when the population had exceeded certain assigned limits. * * * The Christian writers from the beginning denounced the practice not as being simply inhuman, but as being murder. Abortion was placed in the same category as infanticide and the stern sentence meted out to the guilty person impressed on Christians more than mere exhortation a sense of the enormity

*Read before the Orleans Parish Medical Society March 28th, 1927.

of the crime. By the council of Ancyra the guilty mother was excluded from sacrament until the very hour of death. This sentence was reduced * * * but the ofrense still ranked amongst the gravest in the legislation of the church. The emphasis placed on the crime was due to the firm conviction that abortion not only destroyed a life, but that as baptism was seldom performed an immortal soul was damned. It is probably to a considerable degree this doctrine to which we owe in the first intance the sense of the value and sanctity of infant life which so broadly distinguishes Christian from Pagan societies and is now so thoroughly incorporated in our moral feeling as to be independent of all doctrinal changes."

THE LOUISIANA LAW.

Section 807, Revised Statutes of Louisiana reads, as follows: "Whoever shall feloniously administer or cause to be administered any drug, potion or any other thing to any woman for the purpose of procuring a premature delivery, and whoever shall administer or cause to be administered to any woman pregnant with child any drug, potion or any other thing for the purpose of procuring abortion or a premature delivery, or whoever by any means whatsoever shall feloniously procure abortion or premature delivery shall be imprisoned at hard labor for not less than one nor more than ten years."

This statute differs in no essential particular from legislation on the same subject in other states and in other civilized countries. A few comments based upon court decisions will elucidate it.

1. Proof that the woman is pregnant is necessary only when she is charged with the offense.

2. Murder, as distinguished from abortion, is a felonious killing of a reasonable creature in being. If the child is born alive and dies by reason of injuries inflicted before birth, it may be murder. If, in the course of a felonious act, a person causes the death of the mother, that is murder.

3. A person having control over a pregnant woman who induces her to take violent exercise with the intent to produce abortion has been held guilty.

4. The drug need not be a poison in the general acceptance of the term, but if it produces abortion, it is held to be noxious. It has been decided that the quantity prescribed may be admittedly insufficient to cause abortion, yet the intent constitutes guilt.

5. The act of administering a drug consists not simply in furnishing or prescribing it but also in directing or causing it to be taken, but neither a delivery of the drug by the hand of the one alleged to have administered it, nor the taking of the medicine in the presence of the defendant seems to be necessary for proof of guilt.

6. Voluntarily taking by a woman of a drug furnished by another is a fact tending to show the drug was administered by such other.

7. In general, advising a woman to take a drug with intent to procure abortion may, under the provision of certain statutes, constitute a criminal offense. It is not necessary, it seems, to the consummation of the offense that the woman should actually take the drug.

The above is a greatly condensed synopsis of various opinions and decisions. It is enough for the guidance of every physician and to go beyond it would simply entail the narration of a mass of technicalities.

The enforcement of the law is a responsibility of the district attorney, and the cases are brought to his attention through either the medium of the coroner's office or through the Louisiana State Board of Medical Examiners. The work of this board has exerted a very powerful influence on the standards of medical practice in the state, but its activities are little known and

less appreciated. It may suspend the licenses of either physicians and midwives at its discretion, but such licenses may not be revoked without due process of law. It may also refuse to renew licenses. If a license is suspended or refused re-issuance, it may be recovered only after legal process. The Amended Medical Law of Louisiana went into effect in 1919, and the following is a brief synopsis of the work of the Board in curbing abortionists since that time:

The certificates of nine mid-wives were suspended or not renewed for periods ranging from one year in two instances to five years in one instance. Four of these cases were decided on evidence obtained after investigation by the board and five from evidence submitted by patients or doctors.

Eighteen additional cases in which midwives were accused were acted upon. In eleven sufficient evidence to obtain conviction could not be procured. Two cases were taken to the criminal court but both were dismissed In one case the dismissal was due to serious illness of the mid-wife. In one case the accused left the state. About twenty mid-wives have been called to the office and warned. The board has employed its own investigators, or those furnished by private detective agencies, the latter policy finding more favor at present.

Two persons engaged in the practice of mid-wifery, but not so licensed, were investigated by the board.

One physician's certificate was suspended and not renewed. Seven physicians were investigated by the board, one affidavit was filed and dismissed. In three cases an affidavit was refused by the patient and in three sufficient evidence could not be obtained. One case is now pending. One case was prosecuted but no conviction was obtained.

The results of the law cannot be measured by the number of convictions because the statute was designed primarily not to punish the offender but to prevent the offense. The State Board is sincere and active and its attitude has been a pronounced deterrent to malefactors. The veiled advertisements of abortionists have diminished greatly in number since it was learned that such advertisements drew the unwelcome attention of the authorities. Investigators from the board, seeking to obtain evidence, have been refused any treatment on the ground of fear of the law. In many instances there was a moral certainty of the guilt of the accused, but various obstacles account for the lack of convictions. It must be remembered that a large percentage of the community is in sympathy with the abortionists, and that drastic changes in criminal law with the requirements for evidence very much reduced would be necessary before we could expect more convictions. The pronouncement "Innocent until proved guilty," is sometimes a source of irritation to the non-legal mind.

The next phase of the subject involves a sharp conflict of opinion in the minds of various observers. It concerns the responsibility of the physician in reporting cases of abortion. The following is the legal view of privileged communications: "A physician may not testify as to the facts learned while he attended the patient in his professional capacity. He may testify as to facts learned before or after." A belief on the part of the patient, acted upon by him, that the visit of the physician is purely professional, precludes disclosure. The privilege extends only to matters which are in their nature confidential and does not prevent a physician from testifying as to matters, the disclosure of which involves no breach of professional confidence." Professional communications are not privileged if made in furtherance of a criminal purpose. This epitomizes testimony in court and the Hippocratic oath enjoins under all circumstances a respect for confidences. It is interesting, however, to realize that there are opposing argu-

ments. An essay written by Lord Birkenhead, Lord High Chancellor of Great Britain, quotes a case of an English doctor who was proven to have performed the operation for criminal abortion over four hundred times. He says that the medical men must have been aware of the facts and continues: "One becomes impatient of a claim set up by a medical practitioner that he is entitled under a plea of privilege to neglect the obvious duty of a citizen and to abstain from giving to the proper authority information that would have saved many a life and put an end to a social pest. The plea of a doctor that in respecting his clients' confidence, he is obeying his professional etiquette, is frivolous."

Mr. Justice Hawkins gives another viewpoint, and one far more consistent with the general attitude of our profession: "I doubt very much whether a doctor called in to assist a woman, not in procuring an abortion, for that in itself is a crime, but for the purpose of attending her and giving medical advice would be justified in reporting the facts to the public prosecutor. Such action would be monstrous cruelty."

In all fairness to our profession, it may be stated that we are usually much in the dark as to what constitutes sufficient evidence. Even when we are certain that a known individual has procured an abortion in a particular case, we realize that an accusation not fully supported is more apt to be looked upon as slanderous and malicious than as an effort to help the community. That the authorities are not informed more frequently is due to another very familiar factor, the difficulty in obtaining the consent of the patient to the signing of an affidavit and to disclosure. The advisability of reporting abortions has caused so much agitation in Great Britain that the Royal College of Physicians finally adopted the following resolutions:

1. That a moral obligation lies upon every medical practitioner to respect the confidence of his patient, and that without her consent, he is not justified in disclosing information obtained in the course of a professional attendance on her.

2. That every medical practitioner who is convinced that criminal abortion has been practiced on his patient should urge her, especially when she is likely to die, to make a statement which may be taken as evidence against the person who has performed the operation, provided always that the chances of recovery are not thereby prejudiced.

3. That in the event of her refusal to make such a statement, he is under no legal obligation, so the College is advised, to take further action, but he should continue to attend the patient to the best of his ability.

4. That before taking action that may lead to legal proceedings, a medical practitioner will be wise to obtain the best medical and legal advice available, both to insure that the patient's statement may have value as legal evidence and to safeguard his own interests, since in the present state of the law, there is no certainty that he will be protected against subsequent litigation.

5. That if the patient should die, he should refuse to give a certificate of the cause of death and should communicate with the coroner.

The writer is not aware of any similar set of resolutions for the guidance of the medical profession of the United States. The moderation of expression and the conservation of the above might well be taken as a model.

It was thought that the viewpoint of physicians engaged in active practice would be of the utmost value in arriving at certain conclusions. Accordingly, a questionnaire was sent to one hundred and twenty-five (125) doctors thought to be interested in obstetrics. Forty-six (46) replies were received. Five (5) questions were asked. These are given below with a synopsis of the answers:

1. What percentage of abortions is induced? Thirty-two (32) replies were received. The estimates ranged from fifty to one hundred per cent with an average estimate of 77.4 per cent.

2. My personal experience has been that mid-wives are the principal offenders and next to them the patients. Does this correspond to your experience? There were thirty-nine (39) assents. One physician stated that it was probably correct. One blamed mid-wives and doctors equally, another patients and mid-wives equally.

3. Do you believe that any change in the present laws is necessary or advisable? To this fifteen (15) replied "yes" and twelve (12) "no". The remainder amplified in a manner that showed that considerable thought had been given to the matter. Many stated that laws cannot avail and that the moral standard of a community counted more than statutes. One advocated the abolition of mid-wives, and several proposed raising the level of midwifery. The fact that the law requires a witness of the act (a condition almost impossible of fulfillment) and that both patients and relatives shield the guilty was noted with regret. Those that believed that the laws were adequate but that enforcement was lacking might make the same criticism of all criminal law, which, to the lay mind, seems an imposing collection of legal loop-holes interspersed with stern threats of penitentiary sentences. A few physicians admitted unfamiliarity with the laws. One stated that contraceptives decrease the number of abortions. Three thought that all abortions should be made reportable to the board of health.

4. Is the morbidity high or low? To this question fifteen (15) replied that the morbidity was low and twenty-two (22) believed it to be high.

5. Approximate percentage of fatalities? Of the twenty-two (22) answers returned the estimates varied from .1% to 35%. The average estimate was 12.5%.

Before discussing the actual statistics, it is well to remember that accurate estimations of death rate, outside interference, morbidity, and method of induction of abortion cannot be gathered. The very nature of the offense leads to concealment and prevarication. Hospital cases, in a strange and sometimes antagonistic atmosphere, will not tell the truth. Many have been bound to secrecy by the most solemn oaths. We get a clearer view of the subject during the course of private practice.

The writer was especially anxious to arrive at some conclusion as to the death rate from criminal abortions, but finally decided that reliable figures were not available. At the city board of health such deaths are filed under the headings of septicemia or peritonitis, and there are frequently misleading statements in the actual death certificates. There are annually between six and seven thousand deaths in the City of New Orleans, and a thorough review of the certificates of the entire number would be necessary before any information could be gathered. The routine taking of histories has demonstrated to physicians that there are thousands of abortions, spontaneous or induced, that never require medical care. We are called to treat the complication, ordinarily pain and hemorrhage, and occasionally sepsis. Just as it would be unfair to judge from hospital statistics the true mortality of influenza, so it is inaccurate to judge from the same source the mortality of abortions.

The records of the coroner's office during the period from January, 1923, to October, 1926, were reviewed. These covered 4,825 deaths. Of these 20, less than one-fifth of one per cent, were classed as being due to abortions. Two deaths were said to be due to criminal abortions, two as being probably due to criminal abortions, five were labeled spontaneous and the remainder simply as abortion. The immediate cause of death in every instance was given as peritonitis and septicemia. The coroner is an officer of the law, and is unwilling to place

the stigma of criminality without definite proof. However, "When death follows abortion in response to acute sepsis, one is justified in assuming that the abortion was criminally produced." (H. Marx.) Of these twenty fatal cases, nine were colored and eleven were white.

Phillips concluded from a questionnaire answered by seventy-five (75) physicians that in the localties in which they practiced, 63.5% of abortions were criminal. The average death rate was 2%. Royston believed that between 20 and 25% were induced. He thought that the most dangerous were those performed by mid-wives, next the self-induced, and finally those done by physicians. In other words, danger decreases in proportion to conservatism and cleanliness. The introduction of foreign bodies constitutes the greatest hazard, and it is fortunate that the pelvic tissues are gifted with high resistance.

Analysis of the records of Charity Hospital of Louisiana gave instructive results. The system of nomenclature is unnecessarily cumbersome and renders investigation difficult. For example, the term "abortion" is applied to the termination of pregnancy in the first trimester, miscarriage to the second, and premature delivery to the third. The final diagnoses, however, do not follow this classification and we find so-called miscarriages mixed with the abortions. One group of histories is headed induced abortions. A second group contains diagnoses of complete, incomplete, inevitable, threatened, spontaneous, missed and septic abortions. The miscarriages are divided into spontaneous, induced and threatened. There are sound objections to the use of the terms complete and incomplete. If by the term complete we imply expulsion in toto of the uterine contents, we are simply describing the termination of an abortion, and a return to normality. A complete abortion requires no treatment. It would facilitate investigation and filing to divide abortions into three classes: criminal, spontaneous and traumatic. The term spontaneous should cover all cases due to local or constitutional disease. The term traumatic should be applied after strict investigation to those cases in which it is believed that the abortion was due to external, violent and accidental injuries. The term miscarriage should be discarded.

Charity Hospital Records (February, 1906-October, 1926):

Number of induced abortions	120
Number of miscellaneous abortions	2,536
Number of miscarriages	322
Total	2,978

Analysis of induced abortions:

White, married	70
White, single	27
Colored	23
Alleged self-induced	37
Alleged induced by midwife	35
By professional abortionists	1
Admit criminality with vague allegations	9
Alleged induced by doctor	1
Traumatic origin alleged	14
History indefinite	23
Fatal cases (10%)	12
Mid-wife accused	6
Self	1
History indefinite	5

Causes of death:

Acute nephritis	2
Peritonitis	7
Septicemia	2
No diagnosis	1

There were five blood cultures on fatal cases, two of which were positive. One showed staphylococcus aureus and one a hemolytic streptococcus.

There were two perforations of the uterus (one found at autopsy, one by laparotomy). A mid-wife was accused by one patient. The second alleged self-induction.

Status of patient at completion of hospital stay:

Cured	84
Improved	15
Deserted	9
Died	12

Maximum febrile reaction:	
Less than 100 degrees	56
Between 100 and 101 degrees	13
Between 101 and 102 degrees	11
Between 102 and 104 degrees	24
Over 104 degrees	11

Analysis of the last one thousand (1000) histories of the mixed group, including the diagnoses of complete, incomplete, septic, threatened, missed, inevitable and spontaneous abortions:

White, married	537
White, single	41
Colored	422
Admittedly criminal	69
Alleged induced by mid-wife	39
Alleged self-induced	21
Statements vague	6
Alleged induced by doctor	3
Fatal cases (.6%)	6

Causes of death:

Myocarditis	1
Eclampsia	1
Tetanus	1
Septis	3

The case of tetanus gave no history and died a short time after admission. It was not regarded as a coroner's case. An autopsy was refused.

One case of post-abortal infection was admitted moribund and the history contained the comment "criminal?" The second showed distinct trauma to the cervix, strongly suggesting instrumentation. This was a coroner's case. The third fatal case of sepsis gave no history of interference. She remained in the hospital eleven days and it was believed that a broad ligament abscess had ruptured into the peritoneal cavity.

Eliminating the deaths from eclampsia and myocarditis, there remain four fatalities in this group attributable to abortions. The case of tetanus is not sufficiently described to enable the reviewer to decide whether the abortion was an incident or whether tetanus followed it. In the latter case there must have been the introduction of a foreign body and therefore, criminal intent. Two of the infected cases were under strong suspicion, leaving only one out of one thousand or less than .1% mortality, if we judge from evidence given by the histories. It may be mentioned that none of the six fatal cases admitted induction of abortion.

Total histories of miscarriages February, 1906, to October, 1926	322
Spontaneous	277
Induced	7
Threatened	38
Fatal cases	2
Alleged induced by mid-wife	1
Alleged induced by physician	1

(Both died of septicemia.)

Analysis of the last 40 personal cases:	
Married	37
Unmarried	3
Mid-wives accused	19
Physicians accused	3
Histories open to grave suspicion	6
Apparently spontaneous	10
Self-induced	2
Perforation of uterus (by physician)	1
Death (eclampsia)	1
Septic cases	5

Altogether, 1482 histories were reviewed. There were 21 deaths, a mortality of slightly over 1.4%. Seven deaths may fairly be said not to have been due to abortion, leaving a corrected mortality of 1%. In practically all of the fourteen deaths from sepsis, there was either definite admission or strong suspicion of criminal interference.

The majority of patients who apply to us for the induction of abortion range in attitude from firm determination to absolute desperation. Whether their reasons are financial, eugenic, or based on fear of disgrace, we can seldom persuade them to deviate from their resolution. However, a sympathetic and tactful pointing out of the dangers of sepsis and sterility is the utmost that a physician can offer. We drive a certain number of women to incompetent and brutal operators when our own care would obviously be more efficient.

Subsequently, we are called upon to repair the damage that abortionists have inflicted. These cases give us food for serious thought, but the writer can offer no solution to the difficulty. We have the slender consolation that the inflexible attitude of the medical profession may act as a deterrent. At least we may show our appreciation of the psychology of these unfortunate women by refraining from either sanctimony of abuse. In passing, it may be said that in treating post-abortal cases, no effort should be made to force the confidence of the patient unless the disclosure of the cause would alter materially the treatment. After all, some abortions are spontaneous, and the suspicion of criminality, if directed against an innocent case, is extremely offensive.

CONCLUSIONS.

1. The death rate from criminal abortion is low—probably less, all cases included, than 2%. The general impression of the death rate is erroneous, first, because many cases are not seen by physicians, and second, because only the very sick cases are suspected of interference, and the patients who make uneventful recoveries are often thought to have aborted spontaneously.

2. The death rate will be still further diminished by the popular knowledge of asepsis, and by the adoption of conservative treatment, as opposed to operative interference, by the majority of the medical profession.

3. In this community death from hemorrhage is rare. There was no death from this cause in the 1482 cases reviewed, neither were there any deaths from shock, air embolism or gas bacillus infection.

4. Any factor that reduces the number of unwelcome pregnancies automatically reduces the number of criminal abortions. Contraceptives, condemned by both church and state, are now being widely sold. This is in response to the law of supply and demand. While it is not intended to provoke an argument on the merits and disadvantages of birth control, contraceptives are probably the greatest single factor in preventing illegal terminations of pregnancy.

5. The vast majority of induced abortions occur in the married. Laws directed towards increasing the responsibility of the father could at best solve only a minor part of the problem, and would be almost impossible of enforcement.

6. The condemnation by certain churches of therapeutic abortion has had a salutary effect in preventing the evils of ill-timed interferences. An abortion performed for insufficient reason is a criminal abortion, and the indications for interruption are becoming steadily less numerous. It is likely that in the future arguments based on a belief in eugenics will have more force than at present, but the profession as a whole is far from being convinced of their practicability. Two of the major menaces to full-term pregnancy, pernicious vomiting and diabetes, may now be controlled in the great majority of instances. Certain other indications are yet beyond the reach of therapy, but even then action should be sanctioned by consultation of the utmost competence. The physician should not lose sight of the fact that he is deliberately destroying a possible life, and that the only real justification for such an act is the saving of another and more valuable life. It is suggested that therapeutic abortion be limited to those cases in which both lives would inevitably be sacrificed. In other words, in the event of a hopeless illness on the part of the mother, the possible prolongation of maternal life should not be sufficient reason to interrupt pregnancy before the fetus is viable. Niedermeyer remarked that "moral theology is not pervaded by so narrow and blind a type of fanaticism as might be supposed, but on the contrary reveals a certain understanding of and sympathy with conflicts of conscience."

7. More laws are not needed. The present laws act as a powerful deterrent and

this is all that may be expected. In twenty-five (25) states during a period of ten (10) years or more there were only forty-four (44) convictions of abortionists.

8. At least one-third of all induced abortions are due to the patient alone. Legislation is as futile in this matter as it is in suicidal cases. There is no record of a trial in the United States of a woman for self-induced abortion. In nine (9) states she is guilty in theory of a felony, in seven (7) states of a misdemeanor and in the remainder there is no statute.

9. No laws can abolish the sale of all possible abortifacients, but advertising and flagrant malpractice can and have been limited.

10. The chief responsibility of the medical profession, though not its entire responsibility, lies in the recognition and cure of disease. Preventive medicine, however broadly we interpret the term, can hardly be stretched so that the burden of abolishing criminal abortion lies solely on our shoulders. The public at large, the church, the legislators, as well as the physician, must share in the task.

DISCUSSION.

Dr. E. L. King: Dr. Ficklen has so thoroughly covered the subject of criminal abortion that there is little I can add. However, it all comes down to the consideration of the midwife. Doctors, of course, are responsible in a certain small percentage of the cases, but as far as my personal experience is concerned the performance of criminal abortion by a physician is uncommon. So we come back to the question that has been agitated for years, that of the midwife. She has existed, obstetrically speaking, since the dawn of humanity, while the doctor has been practicing obstetrics for only a few years, comparatively speaking. Couvelaire, in one of his papers (when he was installed as head of the Bandelocque obstetrical clinic in Paris) reviews the struggle of the obstetricians of Paris in trying to gain a foot-hold in the hospitals there. It was quite a struggle, for the midwife had the services and it was a long time before the surgeon could get in. In fact, in the middle ages physicians were not allowed to officiate in normal deliveries; they were only called upon to assist in abnormal cases; that was their function. Even in this country the physician as an obstetrician is of recent date, but the midwife has been with us always. The difficulty is perhaps not insurmountable, and probably the best method to help overcome this evil is to raise the standard of the midwife. That is the way the European authorities work it and, where she is strictly regulated, the obstetrical records are good.

In Germany, since the world war, criminal abortion has been on the increase and there is no telling what the figures are now. So it is not wholly a question of enacting laws (and enforcing laws against this practice is extremely difficult), but a question of raising our standards. Raise the standard of the midwife, the standard of her pay; secure women of better moral tone, with better education, i. e., better midwives and the result will be fewer criminal abortions. Eliminate the midwife and you require something in her place. There are many people who cannot pay anything like what a substitute fulfilling the requirements would demand and it is a case of this work being done by those who can accept the lower wage. Therefore, as already stated, it remains with us to raise the standard of the midwife.

Now with regard to the enforcement of the law. We have laws, yet, as Dr. Ficklen says, what happens? In several instances I have had a lawyer delegated by the State Board of Examiners to take the sworn statements of patients and once had two patients in the same ward at the same time who gave me sworn statements implicating the same midwife. Prosecution in these cases is not easy. It is hard to secure action on the part of the legal authorities even with the active co-operation of the State Board of Examiners and with sworn statements as evidence. I recall one case where a woman died in the hospital. Her people had uncontrovertible evidence that an abortion had been performed. Witnesses had seen her go into the midwife's house, other women awaiting their turns had seen her pass through on her way out. The case was taken to the authorities. The authorities asked whether anyone had actually seen the instrument introduced into the patient's uterus. No one had. The evidence was hence no good. So much for the attempt to secure results by court procedure.

As regards treatment, Dr. Ficklen is right in stating that the policy of non-interference is best. We get many of these cases at Charity Hospital and our rule is to let them alone unless there is hemorrhage, and this happens but seldom. Another point that Dr. Ficklen has brought out is that a patient seldom dies of hemorrhage. I have not had a single case of death from hem-

orrhage following criminal abortion. Of course if the cervix is standing open and the uterine contents are portruding therefrom, gentle removal is indicated. If the cervix is closed, we refrain from active interference, even though we know that the uterus is not empty, unless our hand is forced by free bleeding.

Dr. Leon J. Menville: The subject of abortion, so ably presented by Dr. Ficklen, is one of great importance and deserving of careful consideration. I wish to thank him for his kind remarks relative to the activities of the State Board of Medical Examiners in cases of criminal abortion. Our Secretary, Dr. Harrison, is fully cognizant of the situation and his untiring efforts toward applying an effective remedy are well known to the Board.

We have always co-operated with the profession in every possible manner, realizing that without their assistance in reporting cases of abortion we would be seriously handicapped. Our activities are dependent upon reliable information and co-operation of the patient. As an example: Dr. E. L. King reported a case to us, and obtained a sworn statement of the patient while very sick, accusing a certain midwife of performing the abortion. We immediately investigated the case and had the midwife in question come to the office of the Board and, to our surprise, we were presented with another sworn statement from the same patient, absolving the midwife, giving as an excuse, that the first sworn statement was obtained when she was very sick and did not know what she was doing when she signed the papers.

The State Board of Medical Examiners is not given the power of prosecuting persons performing criminal abortion. Should such persons be midwives, we have the power of refusing to renew their certificates, and prosecute such midwives who continue to practice after they have been refused renewal. You can at once understand the value of the renewal clause in the medical act, affecting not only midwives, but physicians as well.

Midwives are placed under the supervision of the State Board of Medical Examiners as provided by law. Before obtaining a license to practice their profession they must satisfy the Board as to their moral character and pass a satisfactory written examination. The midwives of New Orleans are well organized. They have a Midwives' Association that meets regularly, when papers are read and lectures given them by medical men. The Midwives' Association of New Orleans co-operates with the State Board in matters of abortion and should the State Board refuse to renew a license of one of their members, this member is dropped immediately.

Dr. F. M. Johns: In connection with Dr. Ficklen's paper it is interesting to note that in a recent issue of the J. A. M. A. the Berlin letter recounted the letting up of severe penalties for abortions in Germany, and stated that all restrictions on abortions had been removed in Russia as long as they were properly performed by licensed physicians—and that the Soviet Hospitals were overcrowded with patients of this type.

Dr. Ficklen (closing): The present situation is simply an outgrowth of the law of supply and demand. The financial returns for the individuals who produce abortions are so great that there will always be a certain number of people who are tempted. The rigorous training given to midwives and physicians has robbed the procedure of many of the dangers from sepsis which formerly existed.

APPENDICITIS DUE TO BACILLUS TYPHOSUS.*

WILLARD H. PARSONS, M. D.,

VICKSBURG, MISS.

A review of the literature for the past twenty-five years indicates that appendicitis due to B. typhosus is comparatively rare. Probably no organ in the body has received more attention than the appendix, and from this study humanity has reaped a golden reward. Typhoid fever has likewise been thoroughly investigated, and long years ago it was stated that not uncommonly this disease leaves as its legacy various lesions of the biliary tract.

It has often been pointed out that quite frequently an infected appendix may result in an involvement of certain of the other intra-abdominal organs. It is rather interesting to note the very divergent opinions expressed as to the frequency of the invasion of the appendix by the typhoid bacillus. It would seem that such infection may well occur by contiguity as well as by the vascular and lymphatic routes.

---

*Read before Staff Meeting of Vicksburg Sanitorium, Vicksburg, Miss., Nov. 10, 1926.

The appendix, I think, unquestionably shares in the pathology of typhoid fever. Typhoid ulcers occur largely in the lower ileum, which histologically is not unlike the appendix in certain features, and anatomically is not far distant. From time to time various unusual causes of appendicitis have been suggested. Always it has ultimately been shown that the main offender is B. coli.

Wooley, fairly recently, tabulated a series of one hundred appendices of which sixty-six, by histologic methods, were found actually to be acute.

By careful bacteriologic examination the organisms found in a large majority of cases were B. coli. Whereas, appendicitis due to B. typhosus may not comprise more than a very small percentage of the cases of appendicitis, I believe, nevertheless, that in cases of typhoid fever, infection of the appendix is not so very common.

Sands, in 1857, brought to the attention of the Pathologic Society of New York a case of general peritonitis caused by a ruptured appendix, and in this case the solitary and agminated glands of the small intestine had the appearance that often is found in typhoid fever.

Murchison, in 1865, reported a case of perforated appendix in which there were typhoid ulcers in the ileum and cecum.

Moore, in 1883, presented four cases to the Pathologic Society of London.

Fitz, in 1891, reviewed one hundred and sixty-seven cases of perforating typhoid ulcers, five of which were in the appendix.

Hopfenhausen studied thirty appendices during an epidemic of typhoid fever. In two there were perforations in the appendix. In the majority there was marked cellular infiltration of its walls.

Osler, from a study of five hundred cases of typhoid fever, stated that abdominal pain and tenderness is present in three-fifths of the cases, but he made no mention of the infection of the appendix, although he noted that sixteen cases had cholecystitis.

Nelson stated that perforation occurred in two per cent of 13,800 cases of typhoid studies; that the perforation was usually in the lower ileum and that it had occurred in the appendix.

Ochsner, in a study of one hundred and sixty cases of appendicitis, found the streptococcus alone in two cases, enterococcus in three, staphylococcus in one, and B. coli in one hundred and fifty-two.

DaCosta makes no mention of the condition.

Warbasse does not comment upon the frequency of the condition, but lays down the dictum that typhoid appendicitis should be treated the same as typhoid fever and that appendicitis coincident to typhoid should be treated as appendicitis.

Rosenberger says that acute appendicitis due to B. typhosus is comparatively rare. (Personal communication.)

Broders stated that eighty-seven cases of typhoid fever have been observed at the Mayo Clinic with one coincident appendicitis, which presumably was due to the bacillus typhosus.

Deaver believed typhoid fever to be one of the remote and at times direct cause of appendicitis. He believed lesions of the appendix to be common in typhoid fever, that usually there is a catarrhal inflammation which may progress just as the same process elsewhere in the alimentary tract. We may have later, as the result of infection, a stenosed organ.

Deaver quoted an observer who found, in thirty fatal cases of typhoid studied, eighteen cases of appendicitis and in four of these death was directly due to the appendiceal infection. He stated that he has had one case of appendicitis due to B. typhosus without general typhoid. Few such cases are found in the literature.

Elmer believed that appendicitis is not frequent with typhoid fever, but that typhoid ulcers of the appendix are fairly common.

Gage reviewed this subject and collected in systematic fashion much of the literature pertaining to it. He operated upon one case of appendicitis due to B. typhosus and found B. typhosus in the culture from the appendix.

Amich and Stokes reported a similar case in 1905. In this instance typhoid fever had occurred thirteen years before. Culture from the appendix at the time of its removal showed B. typhosus.

Skelton reported one case in 1917 and referred to one other.

Ridgeway reported two cases, but culture was not made in either case and in only one was operation performed so the diagnosis must be accepted with question.

Carter had five cases of appendicitis complicating typhoid. In two recovery followed operation.

Widal reported a case of appendicitis due to para-typhoid. Operation was performed upon the sixth day. Both the culture from the appendix and the blood stream showed para-typhoid bacilli. This case recovered.

Hendon has had one case in which the appendix perforated at the site opposite the mesentery, which incidentally is a rather unusual location for perforation.

In this connection a case of my own is of some interest:

W. I. Colored male, age 25, carpenter.

Father dead, age 40, cause unknown. Mother 50, living and well.

One brother living and well, 28. No brothers dead. Three sisters living and well. Two sisters dead, causes of death and ages attained unknown.

Tuberculosis, cancer, renal diseases negative.

Personal history: Health always good. Uses tobacco. Alcohol occasionally. Has been carpenter for six years. Usual diseases of childhood. Gonorrhea. Denies lues.

C. C. "Pain in stomach." Saturday morning, two weeks ago, had headache and fever developed. He remained in bed. No nose bleed, no cough. No pain except headache. Diarrhea. Headache frontal in type and more marked on right side. Appetite good. Slept well, no chills. No eruption on skin.

During afternoon of present day sudden acute pain, "Hit me around the navel." Nausea and vomiting. Pain continued and became intense.

Examination 9 P. M., October 2, 1924. Patient apparently in pain. Mental condition cloudy. Very poorly nourished, young adult, male. Head and neck negative except that the tongue was considerably coated and some nasal obstruction. The heart sounds were not good, poor in volume. The rate was decidedly increased. Scattered rales over the chest. Abdomen was distended; there was marked rigidity especially in right quadrant. There was exquisite tenderness over the region of the appendix. Temperature sub-normal. Spleen could not be palpated. On account of distention palpation unsatisfactory.

Operation with local anesthesia. McBurney's incision. Perforation of the ileum slightly smaller than a copper cent piece and situated about one and one-half inches from the junction with the cecum. Perforation was closed with a purse string suture. The appendix was very much swollen and ulcer was noticed near the terminal end. Small perforation near the end of the appendix. The appendix was removed, usual technic. Drainage and usual closure. The appearance of the perforation and the ulcer of the appendix suggested typhoid.

Examination of the blood prior to operation:

Total leukocyte count, 7,200.

Differential count polymorphonuclears 65; small lymphocytes 27. Large lymphocytes 8.

Urine: Amber in color. Specific gravity 1016. Acid reaction. Albumen one plus. Acetone three plus. Diacetic acid one plus. A few blood and pus cells present. Coarsely granular casts four plus. Fine granular two plus. Hemoglobin fifty-one percent. (Dare method.) Total erythrocyte count 2,600,000.

Direct smear from the lumen of the appendix showed: Gram negative bacilli, gram positive bacilli. Gram positive cocci, many small lymphocytes and occasional pus cells.

B. typhosus isolated from the feces. B. typhosus isolated from the appendix.

Pathologic report of the appendix: The appendix measured ten cm. in length, and its largest diameter 15mm. Between two and one-half and three and one-half cm. from the distal end there is enlargement. There is an abscess with perforation two mm. in diameter. Cultures taken at this point.

The lumen is small and the mucosa is lined by cells which show an unusual amount of mucus. The sub-muscosa contains an abundance of lymphocytes, outside of which are seen rather larger cells which have frequently been found in typhoid fever. These round cells are seen infiltrating the inner circular layers of the appendix and are also present but in smaller numbers in the outer longitudinal layers. The sections themselves suggest typhoid fever and taken with the history the disease seems certain.

Section for microscopic examination goes through an area which constituted an abscess cavity. The tissue here is necrotic and infiltrated with numerous pus cells.

Diagnosis: The appendix showed the changes of typhoid fever. Small abscess in the wall with perforation.

Recovery from the operation was slow but ultimately complete. Patient ran a typical typhoid course.

Examination May 15, 1925, entirely well.

In resumé it would appear that involvement of the appendix occurs in typhoid fever sufficiently often to be borne in mind, and when definite appendicitis occurs it is my opinion that the appendix ought to be removed and that the mortality will be lower than if palliative measures are tried.

I desire to thank Dr. B. T. Terry of Vanderbilt University, Nashville, Tennessee, and Mr. A. A. Aita, formerly of the Vicksburg Infirmary, for making the laboratory examinations incident to the case.

BIBLIOGRAPHY.

Wooley, Paul G.: Journal of Laboratory and Clinical Medicine, May, 1926, Volume 8, page 802.

Sands: American Medical Monthly, 1857, Volume 7, page 231.

Murchison: 1865, cited by Coulomb, These de Paris, 1899, page 50.

Moore: Transactions Pathologic Society of London, 1883, XXXLV, 365.

Fitz, Boston Medical and Surgical Journal 1891, CXXXV, 365.

Hopfenhausen, Etude sur l'etat et de l'appendice vermiforme dans le cours de la fievre tyhoide, Revue Med. de la Suisse Romande, 1899, Volume 19, 105-133.

Osler, Principles and Practice of Medicine, 8th Edition, page 24. W. B. Saunders and Co., Philadelphia.

Nelson, Loose Leaf Living Medicine, Vol. 1, page 159. Thomas Nelson and Sons, New York.

Oschner, Year Book of Surgery, 1925, page 400.

DaCosta, Modern Surgery, 7th Edition.

Warbasse, Surgical Treatment; Volume 3, page 101. W. B. Saunders and Co., Philadelphia.

Deaver, Appendicitis. Page 74; 97; 201-208. Philadelphia, P. Blakiston's Sons and Co., 1913.

Elsner. The Prognosis of Internal Diseases Monographic Medicine, Volume VI, page 657. New York, D. Appleton and Co., 1916.

Gage, Acute Appendicitis Occurring in the Course of Typhoid Fever. Ann. of Surg., 1915, 62-145.

Ridgway, Two Cases of Typhoid Infection of the Appendix. Kentucky Med. Jour., 1912-13, 11; 484.

Skelton, Typhoid Appendicitis, New York Med. Jour., 1917, 106; 638.

Stokes and Amick, Typhoid Appendicitis without other Intestinal Lesions. Johns Hopkins Hosp. Bull., 1905, 16, 284.

Sumpter, Appendicitis with Concurrent Typhoid fever. Jour. Tenn. State Med. Asso., 1911, 4; 184.

Williams, Acute Appendicitis Occurring on the Eighth Day of a Typhoid Fever. Operation, Recovery. Med. Record 1904, 66. 897.

Widal, F. Un cas d'appendicite paratyphique (A case of paratyphoid appendicitis), Bull. Acad. de med., Par. 69: 283-286. (April 15) 1913.

NOTE ON THE OCCURRENCE OF VARIOUS TINEAE IN NEW ORLEANS.*

WITH REMARKS ON TRICHOPHYTON LOUISIANICUM.

ALDO CASTELLANI, M. D.,

Professor of Tropical Medicine, Tulane University of Louisiana,

NEW ORLEANS.

As well known, the principal Tineae may be classified as follows:

(a) Due to fungi of the genus *Microsporum-Microsporosis.*

(b) Due to fungi of the genus *Trichophyton-Trichophytosis.*

---

*Read before the Orleans Parish Medical Society, March 28th, 1927.

(c) Due to fungi of the genus *Epidermophyton-Epidermophytosis.*

(d) Due to fungi of the genus *Achorion-Favus.*

(e) Due to fungi of the genus *Endodermophyton-Tinea imbricata.*

(f) Due to fungi of the genus *Malassezia* and genus *Cladosporium-Tinea versicolor, Tinea flava, Tinea nigra.*

With regard to the comparative frequency of these various Tineae in New Orleans I have not exact statistics, but I think I can come to some general conclusions based on the experience I have had during the last two years, and on the information kindly given me by Professor Menage and Professor Hopkins who have been in charge of the Dermatological Department of the Tulane Medical School and of the Skin Clinic at Charity Hospital for many years.

Microsporosis, viz., *Tinea capitis* or *corporis* due to Microsporum audouini, seems to be extremely rare; in fact, I have not yet seen a case.

Trichophytosis, viz., *Tinea capitis* or *corporis* due to various Trichophytons occurs, but is not very frequent; it is much less frequent than in Europe or the Northern States of America.

Epidermophytosis in all its forms is extremely common.

Tinea favosa or *favus* is exceedingly rare. Dr. Menage and Dr. Hopkins inform me that the few cases they have seen were among immigrants.

Tinea imbricata is absent.

Tinea versicolor and *Tinea flava* are common; *Tinea nigra* due to *Cladosporium mansoni* and similar fungi is absent, I have seen a case but the infection was probably contracted in Central America.

Trichophytosis due to *Trichophyton louisianicum,*—a type of trichophytosis not

Fig. 1—Trichophytosis due to Trichophyton louisianicum

rare in New Orleans is one caused by the fungus which I have called *Trichophyton louisianicum.* The fungus may attack the scalp and hair as well as the glabrous regions. So far I have seen it only in colored children. The lesions are generally superficial. When the glabrous parts—usually the neck—are attacked, oval or roundish white patches are seen with pityriasic desquamation; an interesting point is that at times a large number of yeast-like organisms are present in addition to the trichophyton fungus, and it is quite possible that the white appearance of certain patches may be due to the presence of the yeast-like fungus; by mycological cultural methods both organisms may be grown; the yeast-like organism is grown much more easily than the trichophyton fungus.

A *moist variety* caused apparently by the same fungus is also met with; in this variety the patches show thick crusts rather than scales and the condition may

be mistaken with a form of seborrhoea on which a pyogenic infection has become engrafted.

CULTURAL CHARACTERS OF THE FUNGUS.

Acid glucose agar 4%. In fully developed cultures three to four weeks old a fairly abundant growth is noted with a central white portion consisting of white duvet springing up from a rather hard mass; the peripheral portion of the growth is yellowish; the submerged portion, viz., the position growing deep into the medium

Fig. 2—Trichophyton louisianicum. Acid glucose Agar culture.

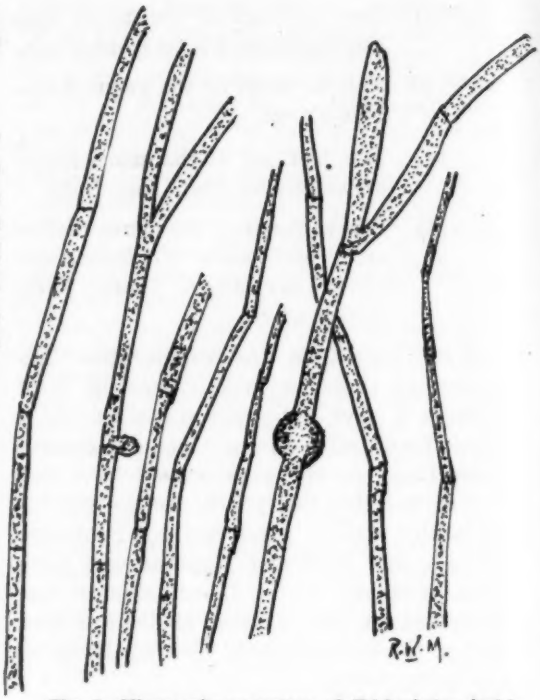

Fig. 3—Microscopic appearance of Trichophyton louisianicum from culture.

frequently shows one or two or several spots of reddish, or brownish-reddish color, the reddish color is usually absent in very young cultures.

Glucose agar prepared with peptone water instead of broth.—The appearance of the growth is identical with that observed in cultures on glucose agar prepared with broth, but the yellow color is much more marked.

Neutral glucose agar 1%.—Growth less vigorous; central white knobs; periphery yellowish.

Casein Digest agar 3%.—Growth fairly abundant, covered with white duvet—portions of submerged growth may be reddish or yellowish-reddish.

Acid maltose agar 4%.—Appearance somewhat similar to that noted in glucose agar cultures, but growth less abundant and yellow color much less marked—or may be absent.

Gelatine agar.—Knobby growth, tending to be almost cereberiform, covered with white duvet—peripheral portion may be yellowish.

Glycerine agar.—The fungus grows profusely; the growth is white with at times a yellowish tinge.

Gelatine.—The fungus slowly liquefies gelatine; usually liquefaction begins on the third or fourth day.

Sugar media.—No gas is produced in any sugar. A slight amount of acidity is occasionally present in levulose and a few other sugars after three weeks incubation.

Microscopical examination of preparation from cultures.—So far the microscopic examination of cultures obtained last year and this year has shown absence of definite spindles, "fuseaux" of the French authors (macroconidia) and if this feature were permanent the fungus could not be placed botanically in either the genus Trichophyton or the genus *Microsporum* or the genus *Epidermophyton.* Temporarily I have placed it for convenience sake in the genus *Trichophyton,* section *incertae sedis.* With regard to microscopic features, the fungus must be separated from the following organisms: *Trichophyton sulphureum, Microsporum flavescens, Trichophyton ochraceum, Trichophyton flavum.*

In contrast to *T. sulphurem* there is no speckled appearance and the cultures are not crateriform; moreover in fairly old cultures reddish or brownish-reddish spots are often seen in the submerged growth; with regard to *M. flavescens* described by Horta in Brazil, 1912, it appears it was microscopically a typical microsporum fungus; with regard to macroscopic features, the whole growth including apparently the cent was of a yellow color; *Trichophyton achraceum* and *Trichophyton flavum* give rise to cerebriform colonies.

Conclusion.—From my own researches as well as from those of Professor Menage and Professor Hopkins it would appear that the following conclusions are correct:

1. *Microsporosis* due to *Microsporum audouini* is extremely rare or absent. I have not yet seen a case.

2. *Trichophytosis* is much less frequent than in the Northern States and in Europe.

3. *Epidermophytosis* in all its forms is extremely common.

4. *Endodermophytosis* (*T. imbricata*) is absent.

5. *Tinea versicolor* and *Tinea flava* are common, while *Tinea nigra* is absent or extremely rare. I saw a case last year but the patient had contracted the affection in Central America.

In this paper I have called attention again to the occurrence of a variety of trichophytosis due to a fungus which I have called *T. louisianicum.* The fungus has the following principal cultural characters: growth fairly abundant, on gucose agar and many other sugar media; in glucose agar the central portion of the growth is whitish, being covered by white duvet and the peripheral portion is yellow or yellowish and in the deep submerged portion there often are some reddish or brownish reddish spots; the growth is not crateriform. Gelatine is liquefied fairly slowly.

LITERATURE.

Castellani: The Gehrmann Lectures, March, 1926.

DISCUSSION.

Dr. Ralph Hopkins: After seeing Dr. Castellani's beautiful specimens and listening to his very lucid talk, I feel that we owe him a word of appreciation for the privilege of hearing what is really the last word in the etiology of these fungus infections.

I would like to ask Dr. Castellani one question. It pertains to the action of the X-rays on cultures of these fungi—whether they have any effect on the growth of cultures? I think that we have all noticed considerable improvement in cases rayed in that group which Dr. Castellani mentions as so common in Louisiana, the epidermophyton infections.

I cannot add anything to what Dr. Castellani, who is master of this subject, has said.

Dr. Henry E. Menage: We are certainly a most fortunate audience in having the privilege of listening at first hand to a study of the Tineas from a man of Professor Castellani's ability. We always learn something when in contact with him and particularly on that subject.

I am glad to hear that he places the Epidermophyton infection as most common in the United States and probably the most prevalent in the South, as I have often called attention to that fact. From an economic standpoint, the Epidermophyton has become an extremely important factor in this community. About three years ago I received a communication from the Surgeon General's office asking for what information we may have on the subject, as the civilian employees in Washington were suffering considerably from that infection and their efficiency reduced. We gave him all the information we had at the time and some months later received a copy of report by Doctors Butler, Houghton and Cooper on Mycosis of the Hands and Feet which proved very interesting and much in line with our experience in New Orleans. The report gave in four groups of men, viz: marines, 22.2%; patients in hospitals, 17.6%; officers, 18.1%; and hospital corpsmen, 30%, with an average for all groups of 20.8%. The duration in individual cases, ranging from six months to twenty-four years, average 1.42 years. When we consider the large number of cases we see in the clinics and in private practice and the percentages in the groups above referred to, in the City of New Orleans, with its population of over 400,000, there should be at least 20 to 30 thousand individuals suffering from that infection in some form or other and in one or more of its favorite localities (hands, feet, inguinal regions, nails and even face). It is no respecter of classes, attacking the professional man, the laborer as well as the woman of leisure, occupation in many instances prolonging the disease indefinitely.

I am also pleased that Professor Castellani mentioned that the anal and vulva regions are often attacked by the Epidermophyton, although pruritus may be the only symptom present.

I enjoyed very much the professor's talk.

Dr. Aldo Castellani (closing): I should like first of all to thank Professors Menage and Hopkins for their very kind remarks. The investigation for which I have been congratulated would never have taken place without their help and assistance.

Professor Hopkins has inquired as to whether x-rays have a direct action on the fungus. I think that the roentgen rays have no very distinct action on the fungus. They retard its development—they do not kill the parasite. Personally I am inclined to believe that the x-ray, while not having a direct action on the fungus make, by their action on the skin, the soil unfavorable for the development of the growth.

ANGINA PECTORIS.*

CHAILLE JAMISON, M. D.,

NEW ORLEANS.

Angina pectoris , that instrument of death, constantly becomes of increasing interest and concern to the American physician when it is realized that diseases of the heart and arteries have become the principal cause of death in the United States, for more than ten years now, having outstripped the great white plague, consumption, and "The Captain of the Men of Death," pneumonia. A disease then that involves both the heart and its principal arteries must arrest our particular attention. Many years ago Osler pointed out that twice as many deaths from angina pectoris occurred among Americans as among the British. We need only pick up the newspapers and note the constant mention of sudden death among notables, to realize that angina pectoris is probably the cause of the major number of such sudden deaths (even though they be described as acute indigestion, apoplexy, and what-not) to have this question brought home in our daily lives, both to the physician and to the layman. There is every reason to believe that the incidence is increasing day by day, and that, in company with other diseases of the heart, the mortality is greater from it than that much more dreaded disease, cancer.

It is surprising that the history of this disease does not date far back. It is almost unbelievable that such dramatic and ter-

---

*Read before the St. Tammany Parish Medical Society and before the Staff of the Hotel Dieu.

rible symptoms, with the almost inevitable deadly result, should not have been noted by the writers of ancient and mediaeval medicine, yet such apparently is the case. Are we to believe then that this disease has only appeared in comparatively modern times? It was first clearly and definitely described by Heberden in 1768, although Dr. Rougnon had described such a case in a letter shortly before this time. John Hunter is known to have had the disease for fifteen or twenty years and to have finally died in an attack.

The cause of the malady has been attributed to different factors—thus Jenner showed its association with diseases of the coronary arteries; Allbutt believed that it was always accompanied by aortitis, with dilatation of the first part of the aorta; Mackenzie taught that the pain could best be considered as an expression of exhaustion of the heart muscle. In the last twenty years it has been very definitely shown that one of the most common causes of angina pectoris of an extremely fulminating and deadly type can, with certainty, be ascribed to coronary thrombosis. The idea that angina pectoris is always due to aortitis and dilatation of the arch of the aorta seems to find little favor at the present time, and we are justified in discarding this as a common cause of true angina, though it is recognized that aortitis is often accompanied by a definite train of signs and symptoms, among which a retrosternal pain, particularly located behind the manubrium, is prominent. No one can doubt who has seen acute dilatation of the left side of the heart that precardial pain, often radiating in character, is a frequent symptom. We need only recall our boyhood days, when perhaps we ran to a point of exhaustion, when we were brought up sharp to a stand-still by shortness of breath and pain over the heart. This is a most attractive theory, and it is certainly confirmed in a large proportion of autopsy cases, where the sclerosis of the coronary arteries is only moderate in extent, though the patient may have had very definite anginal pains during life. We find an analogy for such a condition in the common clinical symptom of intermittent claudication occurring in the lower extremities after exertion, when arteriosclerosis is present. I have heard experienced pathologists say, however, (and it has certainly been my own experience), that they have never seen a case of angina pectoris that did not show coronary sclerosis at autopsy, but that many cases of coronary sclerosis were seen that never had anginal pains. When coronary thrombosis is present, the pathology is so clear-cut that there can be no doubt of its relation to the disease.

The pain originating in the heart, or the root of the aorta, is transmitted first to the cardiac plexus by connecting nerve filaments; it then reaches the nerve centers by two different paths—that of the pneumogastric, which includes the depressor nerve, and that of the sympathetic. The fibers traverse the inferior cervical ganglion and reach the spinal cord by way of the posterior roots of the eighth cervical and the first and second dorsal. The pain radiates towards the periphery, following the distribution of the nerves springing from the roots of the eighth cervical, and the first and second dorsal. These are the circumflex, the internal cutaneous, and the ulnar nerves of the same side. The sympathetic nervous system has usually three direct connections with the cardiac plexus, the superior, middle and inferior cardiac nerves; although all three carry motor fibers, only the lower two contain sensory fibers from the cardiac plexus to sympathetic ganglia. The part that these ganglia play in the distribution of heart pains is of great importance because of certain surgical methods of treatment, which are now advocated, and to which reference will be made later.

SYMPTOMATOLOGY.

Angina pectoris is a disease of middle age, cases under thirty being so uncommon that their occurrence can only be regarded with skepticism unless proved at autopsy. It is far more common in men than in women, and more common among Americans than any other race. Apparently, if the observations of those clinicians with wide experience in this class is to be regarded, the negro is rarely affected by angina; the statistics at the Charity Hospital do not bear out this opinion, and one of my associates, Dr. Robbins, has taken occasion recently to examine the case records of that institution with regard to this point. He found that these records showed the incidence of angina pectoris to be greater among the negroes than among the whites. Let me call your attention, however, to the fact that these cases are unlikely to be bed-ridden, and that records based on house cases are likely to be fallacious for this reason. Only the observation of a large number of clinic cases, and observations of those physicians who practice largely among the negroes can clear up this interesting point. If my own experience is worth anything, based on many years of service in the negro wards of the Charity Hospital, it is that heart disease is much more prevalent among the negroes than among the whites, and particularly heart disease associated with extensive fibrosis of the arteries, but that angina pectoris, in any of its forms, is comparatively rare in this race.

The classical description of Heberden may be taken as the example of true angina pectoris. To quote from Vaquez, "The symptoms are so typical that it is easy to construct a picture in all of its details when the patient has described one of them. The first attack occurs in apparently perfect health. After the mid-day meal, or the evening meal, on quickening his pace a little, the patient suddenly feels behind the sternum at the level of the upper intercostal spaces, a pain which startles and alarms him. At first, this pain is only a discomfort; the patient attributes it to indigestion and thinks that a little exercise will soon dissipate it. He walks on, but the pain, instead of disappearing, increases steadily. It extends across the upper part of the chest toward the shoulder, especially the left, then passes down the arm of the same side, keeping to the inner side of the arm, to the ends of the fingers, especially the ring and little fingers. At the same time, there is an indescribable dread, a firm conviction that he will die if the agony continues. Mastered by the pain, the patient stops walking, and, as if by magic, the pain stops too, either immediately or, after a few minutes, gradually decreasing in intensity. A new effort at walking is followed by the same result and it is only at a very moderate pace, avoiding all exertion, that the patient can reach his destination, fearing at every moment a return of the symptoms." Such is the angina of effort, and it must be borne in mind that this train of symptoms may vary to a great extent from the classical. However, the relation of the pain to a heavy meal, or to unusual exertion, such as running after a street car, must be borne in mind; also attacks following emotion, particularly anger and excitement, are to be included under this classification. We do not always find that the pain radiates, and it is not at all necessary for diagnostic purposes that it should radiate down the left arm, as it may radiate in both arms, into the neck, to other portions of the body, or not at all. The patient usually describes the pain in the chest as vice-like, as though the heart were squeezed by an iron hand, and often it is said to resemble a steel-like band encircling the lower chest. A profuse perspiration, Hippocratic facies, are common; only too often such attacks are concluded by the patient's sudden death.

The angina pectoris of decubitus differs from the angina of effort only in the fact that the attacks come on at the time of

most complete repose, usually at night. The patient is awakened from sleep by a terriffic pain, grinding and crushing the chest, soon radiating to the shoulders and arms, indescribably agonizing in character. The sense of impending death is acute. The patient sits up in bed, pale, livid, and anxious, with beads of perspiration on the brow, a short hacking cough, and the expectoration perhaps, of a frothy blood-tinged mucus. Such attacks are prone to last longer than those brought on by effort, and may extend for hours, gradually waning, perhaps waxing again, eventually either to pass off or end in death.

Clinical cases of angina pectoris usually present a mixture of the two types, the angina pectoris of effort eventually becoming associated with that of rest.

The symptoms of coronary thrombosis are usually clear-cut. The patient is generally about forty years of age and may never have had previous attacks of pain, certainly no attacks of a characteristic nature. He has perhaps consulted his doctor for a slight pain in the epigastrium, which is usually attributed to indigestion or "gas." He may be even under the suspicion of having a chronic appendix, gall-bladder, or ulcer of the stomach. Without warning, and at any time during rest or effort, there is the occurrence of a sudden agonizing pain, located over the precardium, which may, or may not, radiate. It is often located with greatest intensity in the epigastrium. The usual methods which the patient has found efficacious in relieving his indigestion, such as warm drinks, bicarbonate of soda, etc., are of no avail. The pain increases in intensity. The patient's expression leaves no doubt of his exquisite agony. The ashen face, bathed in sweat, the labored respirations, the constrained attitude about which there is nothing characteristic, leave us in little doubt of the reality of a stupendous emergency. Only too often such symptoms are soon followed by edema of the lungs, auricular fibrillation, or heart block, with death. Should the patient recover from the attack, the train of symptoms and signs which then follows, is characteristic. In a few days, or a few hours, there is a rise of temperature, usually to 101 or 102, and at this time a pericardial friction rub often makes its appearance. Dyspnoea on the least exertion is common, and there is a sense of soreness and pain in the chest, often accompanied by hyper-algesia. The pulse at this time may show extra-systoles, partial heart block, or auricular fibrillation. The blood pressure is either normal or below normal, and leukocytosis is common.

It cannot be too strongly emphasized that in the ordinary types of angina pectoris the physical examination is entirely normal, nay, it may even be said that these patients appear in the most robust health, and the physical signs lead the examining physician to believe that his patient is an exceedingly good risk. On the other hand, it is common to find angina associated with cardiac hypertrophy and hypertension and this is particularly true of the milder types of the angina of effort.

DIAGNOSIS.

This rests primarily upon the history, particularly if the patient is not seen during an attack. The patient's appearance during a typical attack is so characteristic as to leave no doubt of its nature. He is either in a standing or sitting position, with the forearm flexed on the elbow, with the arm tight against the chest, and the body usually bent toward the left side. The appearance of the face denotes agony. With such cases, then, there is no difficulty. On the other hand, we are often casually told by a patient that he notices on going up stairs, or on other slight effort, that he is often taken with a curious pain on the inner side of his elbow and a numbness and tingling in the fingers. Perhaps a closer questioning will bring out the fact that there is also, at this time, precordial pain. Where such pain is complained of, we may find an elevated blood pressure and an enlarged heart. Again we may find that

the patient complains only of pain in the epigastrium which he suggests is due to too heavy or too fast eating. It is these cases that present nothing classical, with perhaps a normal heart, normal pulse and blood pressure, that tax our diagnostic acumen to its greatest. The diagnosis of angina is scarcely justifiable in these atypical cases unless a most thorough and painstaking general examination, including radiological and laboratory studies of the gastro-intestinal tract, exclude pathology which might explain such symptoms. We must remember that one may have an attack of angina pectoris which is not followed by other attacks for many years; on the other hand, attacks may occur in cycles, every few days for months, and disappear either spontaneously or under treatment. It is a clinical axiom that if one attack of angina has occurred other attacks will inevitably follow sooner or later. The physical signs of coronary thrombosis have already been alluded to and are not to be gainsaid. The electro-cardiogram may offer some help, as there are changes in the form of the ventricular complexes, which are almost pathognomonic of the condition, and, when available, electro-cardiograms are of some aid in diagnosis. However, it is to be remembered that the electro-cardiogram may be entirely normal in patients with angina pectoris, and it is to be emphasized that the correct diagnosis usually can, and should be made, without the aid of graphic methods.

DIFFERENTIAL DIAGNOSIS.

True angina is to be differentiated from psuedo-angina or angina pectoris vasomotoria. This disease is merely a manifestation of hysteria, and if it is borne in mind that it is common in the young, where true angina is extremely rare; that it is also more common in the female, where again angina pectoris is rather rare; and that, finally, it is always accompanied by other symptoms of an unstable nervous system, little difficulty will be encountered. If one sees the patient in an attack, the diagnosis is never seriously in doubt. As nausea and vomiting are common in both angina and coronary thrombosis, and as collapse often occurs, the question of perforated gastric or duodenal ulcer may arise, and perhaps can only be decided after a few hours have elapsed. As this may be disastrous in the case with a perforated viscus, full emphasis must be placed on the previous history and the few physical signs noted above. I have only had to face such a situation on one occasion, and we were then helped by the absence of any abdominal rigidity and the agonizing character of the pain which endured, becoming more and more severe.

TREATMENT.

It is a grave mistake, that has been made for too many years, particularly in the teaching of medical students, that angina is a disease in which treatment is of no avail, and in which the outcome is already written in the book of fate. The majority of text books dilate on the treatment of the attack itself. This is as it should be, but due emphasis must be laid on the treatment between attacks, so that these may be of less frequent occurrence, or may be avoided altogether. It is scarcely necessary for me to mention to any well-informed body of medical men that amylinitrite by inhalation, or a nitroglycerine tablet under the tongue, or by hyperdermic, will relieve attacks and often thereby save life. It should be emphasized that the patient known to have angina pectoris should never be without one of these remedies, and should use them at the first intimation of trouble. This medication has no effect in coronary thrombosis, and in this form of the disease nothing is of avail except morphine by hypodermic and in large and repeated doses, and even this is strikingly lacking in effect. It is just in this question of treatment that a clear understanding of the type of angina from which the patient suffers, is of the utmost importance. Let me first consider the angina of effort; when this diagnosis has been clearly estabished, the direction treat-

ment must pursue is clear and undeviating. This form of angina is evidence of exhaustion of the heart muscle, either due to disease or the muscle itself, or to lack of an adequate blood supply which must be called for under the increased function due to effort, and which is not forthcoming because of narrowing or rigidity of the coronary artery. Such cases should be treated by at least a month or six weeks' rest in bed. Potassium iodide appears to be of value, but for reasons which we do not understand: I advocate its administration in as full dosage as the patient will tolerate. Great attention should be given to the eradication of foci of infection, as the myocarditis and even the arterial spasm may readily be due to toxic products. In this connection it cannot be too strongly emphasized that tobacco should be eliminated. It is not sufficient merely to rest for six weeks and then permit patients to go about their business as cured, for such is not the case. After the initial period of rest they should be permitted to be up for only a few hours a day, and it is wise to insist that business be pursued only during the morning hours, and that from an hour to two hours be spent every afternoon at complete rest.

Where general arteriosclerosis, with hypertension and hypertrophy of the heart are in evidence, I feel that, beside the measures just advocated, a course of Naudheim baths, which can readily be given at home, is of distinct benefit; perhaps of even more value than the Naudheim, especially when hypertension is marked, is the twenty minutes hot bath followed by rest of at least an hour or two. This reduces high blood pressure in quite a remarkable manner, and often brings about relief from all symptoms dependent upon it. In the course of time, and provided no attacks occur, cases with this type of angina may be allowed limited exercise of a mild nature, such as walking or golf, provided this exercise is taken on level ground, and is unaccompanied by sudden exertion or undue excitement. It is unnecessary to say that heavy meals are to be strictly avoided and the patient should eat small amounts at frequent intervals. Alcohol need not be absolutely interdicted, particularly if the patient has been in the habit of using it. Whiskey, well diluted with water, or light wine, may even be of benefit. The use of digitalis is certainly not to be recommended in the majority of cases. My own experience is that it usually does more harm than good, but it must clearly be realized that this question is an individual one and can only be decided on the merits of the particular case under consideration. If it is believed that the angina is due to muscle failure rather than coronary disease, digitalis may be indicated. Where coronary disease is present, however, (and it is present in the vast majority of cases) digitalis seems to do more harm than good. If there is evidence of accompanying failure of the right heart, then digitalis probably should be used, though here again the pain of angina usually disappears when frank heart failure sets in.

It is sometimes stated that this disease is nearly always due to a syphilitic infection and that it accompanies syphilitic disease of the aortic valves and the root of the aorta. Where syphilis is proved, antiluetic treatment should, of course, be instituted, and this is best given by the rubbing of mercury, the injection of bismuth, and the administration of iodides by mouth. I believe that intravenous medication should never be used. In this connection, I believe that the role of syphilis in angina pectoris has been largely overestimated. I am of this opinion, because in the negro service at the Charity Hospital, I see a great number of cases with syphilitic heart disease, and particularly with disease of the aortic valves and the root of the aorta, (aortic regurgitation) yet angina pectoris is a great rarity. I feel then that before syphilis is to be consid-

ered a cause of angina pectoris, it must be clearly and unequivocally proved.

The treatment of the angina of decubitus does not materially differ from that of the angina of effort. Its presence merely emphasizes the necessity for greater diligence in the application of treatment. Coronary thrombosis, during the immediate attack is to be treated by the administration of large doses of morphine by needle. When the attack has subsided, rest in bed must be absolute and an ice cap continuously applied to the precordium. As these patients usually have a low blood pressure there is no necessity for bath, etc. Rest in bed must be maintained until all fever has disappeared and for a minimum period of six weeks. In these cases the advisability of the use of digitalis may tax our judgment to the utmost and no definite rules can be laid down. The question of sympathectomy is being more and more discussed in current medical literature. Levine and Newton writing in the American Heart Journal of Oct. 1925 conclude that some patients suffering from angina have been strikingly helped by cervical sympathectomy. They make a detailed report of seven patients who were selected for sympathectomy, all of whom are alive three months to two years following operation. Only three of these patients, however, were rendered absolutely free from anginal attacks. They point out that it is absolutely necessary that accurate diagnoses be made, and that cardiac infarction be not confounded with angina pectoris. Furthermore, the study of each patient should indicate that there has not been any congestive heart failure, that the musculature of the heart is satisfactory and, preferably, that there is no valvular disease. It has been contended that, as the operation suggested can only relieve the pain, and in no way cure the disease, it may do the patient more harm than good, as the pain is a protective process, warning the patient that he must rest. So far as I know, this operation has not yet been performed in New Orleans.

PROGNOSIS.

*"1. By sudden death in the first seizure.

2. By sudden death or death from myocardial insufficiency after months or years of attacks.

3. By a period of attacks, followed by a long or short period of remission, then a recurrence of attacks, perhaps with sudden death.

4. By a period of attacks, followed by a long period of remission during which the patient dies from some other cause. These instances are spoken of as cures.

5. By an unusually severe seizure followed by death, not sudden, but after hours or days of agony, from a gradually failing heart. These attacks may be initial, or, as is more often the case, follow months or years of less severe attacks.

6. By an unusually severe but not fatal seizure, followed by a period of apparent recovery and months or years later by sudden death from rupture of the heart or gradual death due to advancing myocardial insufficiency."

It can be seen that the prognosis will rest largely upon the cause of the disease, which it is admitted, can only be determined approximately, even after the most thorough study, but, it is safe to say, that the majority of cases are of fairly long duration, and any of us who have practiced for a number of years can recall cases doomed to death years ago, today living in comfort and pursuing useful lives; on the other hand, it is an old clinical axiom that once a person has had true angina he will eventually die of that disease if he live long enough. Let me emphasize that angina is never cured, but is very often ameliorated and life prolonged by proper treatment and understanding.

---

*Quoted verbatim from Hamman, L.—Prognosis of Angina Pectoris. Amer. Jour. Med. Sci. 168, No. 6.

THE PRACTICAL MANAGEMENT OF HYPERTENSION.*

OTIS S. WARR, M. D.,
MEMPHIS, TENN.

Hypertension may be at once both a symptom and a disease. This discussion will be limited to that symptom-complex commonly known as benign or essential hypertension. This will, of course, preclude those cases of hypertension associated with renal insufficiency.

An intelligent treatment of any disease must be based on its known or its supposed cause. Therefore, we shall preface our remarks on the management of this condition with a brief summary of what is known regarding its etiology.

ETIOLOGY.

Heredity. The past few years have witnessed a renewed and an increasing interest in the study of the constitution of the patient. In no condition is there more abundant or more convincing evidence of the importance of heredity than in the one under discussion. No doubt illustrative cases have occurred in the practice of every physician present. Osler emphasized the importance of the kind of tubing with which we are born. He might have referred with the same appropriateness to the quality of the nervous system.

Age. Benign hypertension is pre-eminently a disease of mid-life and beyond. Yet it is surprising to note the number of reported cases occurring during adolescence and early adult life. Where routine examinations have been carried out among this group, as among college and high school students, one is struck with the high incidence of beginning hypertension. In passing we would suggest that an intensive study of this group of early cases would probably clear up much that is now obscure regarding the etiology of this disease.

Sex. The incidence is essentially the same for both sexes. There is evidence indicating that it is more common in women around the menopause.

Occupation. It is generally believed that hypertension predominates among those whose occupation subjects them to an excess of nervous and mental strain. Our own observations lead us to believe that it is quite as common among those who do manual labor as among professional and business people.

Habits. From the data available we are forced to conclude that the use of coffee, tea, tobacco and alcohol have no important bearing on the incidence of the disease. However, there is no doubt that they tend to aggravate the condition once it is established, especially when used to excess.

Infections. The relation of focal infection to hypertension has not been definitely established. Is not there a tendency to attach too much importance to focal infection to the neglect of other causes? In our experience the blood pressure is seldom lowered by removal of foci of infection. However, it is desirable that infection be eliminated for the protection of the heart and kidneys.

Obesity. There is no longer any room to doubt the importance of over-weight as an etiological factor. Where any large group of cases have been studied especial emphasis has been placed on the large number of overweight. We shall speak of this again under the head of treatment.

MANAGEMENT.

Prophylaxis. With our present knowledge of the cause of hypertension what can be done to prevent it? If we recognize the predisposing causes and apply the principles of prevention, the incidence of the disease, we believe, can be materially reduced. We concede that heredity is a predisposing factor, yet how often do we impress this on the families of our hypertensive patients? Closely related to heredity is obesity. We cannot emphasize too much or too often the danger of overweight not only

*Read before the Winona District Medical Society, Winona, Miss., Dec. 7, 1926.

as predisposing to hypertension and other cardio-vascular diseases, but to hyperglycemia and diabetes, both of which, when present, greatly aggravate the hypertension.

Let us now see what can be done after the disease has been established. This discussion will be limited to those cases without myocardial insufficiency. As in all other diseases much depends on early recognition. Since hypertension is compatible with normal health for many years, our only chance of detecting it early is through periodic health examinations. I am persuaded that most of us are not urging the necessity of these examinations as we should. But can the laity be blamed for not applying for periodic health examinations when we doctors are not doing it? When we reflect that cardiovascular diseases constitute the chief cause of death among physicians, is it not time we were beginning to practice what we preach?

REST.

Rest is a sine qui non in any successful plan of treatment, but it must be defined in terms suitable to each individual case. Unfortunately the kind of rest often prescribed consigns the patient to a life of utter uselessness. The result is that many, recognizing the futility of such a plan, for economic reasons, become discouraged and lose interest in their treatment. In order to gain the co-operation of the patient it is important that we indicate a sympathetic understanding of his responsibilities. To one it might mean shorter business or working hours, while for another it might mean a complete change of occupation. The majority can be persuaded to spend more time in bed at night with an enormous saving to the heart. One or two hours rest in the middle of the day will also accomplish much. For the more advanced case the week end spent in bed is worth far more than the annual vacation. In prescribing rest it is very important to be specific in our instructions. If we give general directions they are likely to be interpreted as optional.

DIET.

Since the time when all cases of high blood pressure were grouped under the one head of chronic interstitial nephritis, it has been traditional to restrict protein. Such restriction has usually resolved itself into the elimination of meat, or if any meat were allowed it was in the form of white meat of chicken or fish, presumably because these were thought to contain less protein than the read meats. Now that we know, that in the absence of renal insufficiency, protein in normal quantities has no influence on the blood pressure there can be no excuse for such restriction. Furthermore, it is needless to point out that the mere elimination of meat of all kinds does not necessarily materially reduce the protein. Besides, the body requires a certain amount of protein to maintain a nitrogen equilibrium. And in this connection it would be well to mention that it requires more vegetable than animal protein to maintain this nitrogen balance. The minimum amount of protein needed when the individual is at rest is about two-thirds of a gram per kilo of body weight, and proportionately more when active.

Of greater importance than the amount of protein is the regulation of the total amount of food. As mentioned before, the majority of hypertension patients are overweight. Alvarez has recently shown that the blood pressure even in those with normal weight average 10 mm. higher than those under weight. Some one has aptly stated that one's waist line is in inverse proportion to the life line, that is, the longer the waist line the shorter the life line. Yet it is surprising to note the indifference toward obesity even among the medical profession!

Chlorides. Considerable has been written concerning the relation of salt to high blood pressure. The evidence is conflicting. The majority of observers are agreed that a moderate restriction of salt will not influence the blood pressure. No doubt many of the reported failures were due, as Allen

claims, to inadequate chloride reduction. He states that "no pressure is rightly called irreducible unless the daily chloride excretion has been reduced practically to zero." Moreover, a salt poor diet that is satisfying is not easy to arrange, and in our experience is well-nigh impossible except in an institution which commands the services of a competent dietitian.

Fluids. Too little attention is paid to the quantity of fluids taken. Most of us wait till edema appears before we begin to restrict the fluid intake. Yet there is ample experimental evidence showing that an excessive intake of water will markedly increase the blood pressure. It is not necessary to state that in order to restrict fluids we must first reduce the salt. For the average case a total of 1000 cc. to 1500 cc. in twenty-four hours is ample.

DRUGS.

In this discussion we shall not attempt to mention all the drugs which have been used in the treatment of hypertension but will confine our remarks to a few of those which have been used most effectively. Before attempting to reduce the pressure by the use of drugs it would be well to remember that long-standing cases develop an optimum pressure which must mean that the hypertension is in a measure compensatory.

Iodides. The use of iodides, except when there is an associated luetic infection, is founded on tradition rather than scientific fact. I confess to having prescribed them but if the blood pressure was ever affected I failed to observe it. Allen claims that they not only are of no benefit but are potentially harmful due to their possible interchange with chlorides.

Nitrites. Clinical experience has definitely established the value of the nitrites. The action of few drugs is more certain or more prompt than the reduction of blood pressure by an adequate dose of nitro-glycerine either by mouth or hypodermically. But the effect is evanescent and we would suggest that not infrequently failure to reduce blood pressure is due either to inadequate or too infrequent dosage. Sodium nitrite is more lasting in its effect. But we call attention to the fact that this drug soon becomes inert when prescribed in solution. Erythrol tetranitrate is one of the most dependable vasodilators but it is not unusual to find a patient who cannot take it on account of severe headaches. Amyl nitrite is indispensable as an emergency measure.

Chloral hydrate. We have found chloral hydrate very valuable especially in those cases complaining of excessive nervousness and insomnia. Whether the reduction in pressure is due to direct vasodilation or merely through its sedative action I do not know. Of course, it must be administered with much caution because of the danger of habit formation. Luminal and barbital have been found useful in this type of case.

Purgative. Any purgative will reduce blood pressure temporarily, and the more drastic the greater the reduction. This has led to the popular notion that constipation is a cause of hypertension. Alvarez and his associates have recently published an extensive study of the relation of constipation and hypertension, and they came to the conclusion that constipation has absolutely no effect on blood pressure. Therefore, frequent purgation, except in the presence of edema, is to be condemned. We would caution against the prolonged use of salines.

Liver extracts. Any discussion of the treatment of hypertension would be incomplete without mention of the use of organ extracts, especially certain liver extracts. Again the evidence is too conflicting to warrant any final conclusions. A discussion of this evidence would be beyond the scope of this paper.

PHYSIOTHERAPY.

As a profession we have been slow to acknowledge the value of physiotherapy and as a result it has been exploited by

the charlatans and irregular practitioners. The enthusiasm which is being aroused will likely cause the pendulum to swing to the other extreme. The value of hydrotherapy has long been established as a safe means of reducing blood pressure. The Nauheim (artificial) bath is very helpful especially in the case that fails to respond to the usual measures. It is to be regretted that more of our hospitals are not equipped to give these baths.

Since the close of the world war there has been a steadily increasing interest in electrotherapy of all kinds. As a valuable aid in the treatment of hypertension, high frequency electricity has passed the experimental stage. Sir Clifford Allbut in his last work said "d'Arsonvalization is the most valuable immediate aid we possess for hyperpiesia." Perhaps the greatest danger from high frequency lies in its indiscriminate use. However, it should be said that it possesses less potential danger than many of the drugs which are so freely used.

PSYCHOTHERAPY.

Before deciding on the plan of management we would urge a comprehensive study of the individual. An insight into the personality of the patient is often more important than an exact knowledge of his blood pressure. With great painstaking we note all his previous illnesses and at the same time neglect to inquire into his past life with reference to the psychial influences to which he has been subjected. What is the nature of the environment in which he lives? Does his present occupation subject him to an excess of mental and nervous strain? What about the successes and failures through which he has passed to reach his present position? Is his home life a happy one? Is his income commensurate with his responsibilities? There are times when ambition with its associated worry and hurry is more deadly than chronic infection. It is just as important to know about these things as to know what he eats.

Many of us are in the habit of thinking of psychotherapy as something belonging to the neurologist or psychiatrist and accordingly entirely foreign to the general practitioner. Yet every successful physician employs suggestion. There are few diseases where psychotherapy can be used to a better advantage than in the one under discussion. The worry and apprehension of some of these patients is distressing and without repeated reassurance no plan of management will succeed. In this connection we would mention the danger of too frequent estimation of the pressure. It is also important to emphasize to the patient that the blood pressure is not constant and is subject to wide variation, consequently the reading at any one time does not mean much.

Finally, in considering any plan of treatment, let us not lose sight of the fact that we are dealing, in the light of our present knowledge, with an incurable disease. Our duty then is to teach these patients how best to live with it. Therefore, the plan among other things must take into consideration the patient's economic problem. Failure to do this often results in his being advised to do what he knows is impossible for him and being discouraged, he makes no effort to follow any part of the treatment.

20 SOUTH DUNLAP ST.

MEDICINE IN THE TALMUD.*

MENDEL SILBER, Ph. D., M. D.,

NEW ORLEANS.

The modern doctor who is prone to be provoked by the thousands and tens of thousands who flock to faith-healing and all sorts of quackery, because of the apparently slow progress of medicine might find consolation and compensation in the knowledge that the Rabbis of the Talmud cultivated the art of medicine (it could hardly be called a science in those days)

---

*Address delivered before the Orleans Parish Medical Society, March 14th, 1927.

and devoted themselves to it with surprisingly great zeal and skill. To appreciate fully, however, the importance of the medicine in the Talmud, the date and the character of the Talmud should be borne in mind. To begin with, it contains no special treatise on medicine. Whatever medicine it contains is merely incidental to the discussion of certain laws, rites and religious ceremonies which were carried on by the Rabbis in their effort to interpret the Bible correctly and to apply its teachings to the needs of the times. It may be briefly characterized as a unique and stupendous work in which a whole people (the Jews) deposited the record of their civilization as it existed in Judea and Babylonia from the fourth century before the present era to the sixth century of the present era. This means, then, that the date of its composition is from the fourth century before to the sixth century of the present era. I am emphasizing the date of its composition, because I consider it significant for the purpose of comparison and contrast. Its significance lies in the fact that it furnishes us certain valuable landmarks. It commences at the time when Greece lays the first foundation for the structure of modern medical science through Hippocrates, the "divinus pater medicinae"; it is contemporaneous with the time when medicine consisted of mystery and magic among most of the nations, when it was an object of contempt in the Roman Empire, where it was regarded as unworthy of the occupation of a free man, and it antedates Galen and Soranus by more than five centuries.

Yet, here are some of the surprising facts: The Rabbis hold the physician in the highest respect and consider his services so indispensable to the community that they prohibit living in a city where there is no physician. They carry on their medical studies, not theoretically, but through observations of clinical reactions, through experimentation and autopsies. One Rabbi, Jose ben Chalafta by name, was known as the "experimenter." To further the interests of medicine, autopsies could be ordered by a court of law, as could also exhuming of a body, while quackery was prevented by the system of licensing physicians.

The familiarity of the Rabbis with anatomy, physiology, pathology, and surgery is most surprising. Their descriptions of the bones, muscles, tendons, the respiratory and generative organs, the heart, the blood vessels, and even the nervous system, in many instances lack only the modern nomenclature to be up-to-date in their exactness. The number of bones in the human body is ascertained and every bone in the skeleton is identified. The various muscles are studied and their change of form when in motion is noted. A certain Rab Hisdai makes the remarkable observation that in the so-called Kosher animals, that is, those which chew the cud and have cloven hoofs, the psoas muscle has two accessory muscles with longitudinal and transverse fibres. The nature of the secretory glands, every one of which, they said, secretes a fluid peculiar to itself, was recognized by them two thousand years before Beaumont experimented on Alexis St. Martin. The real function of the stomach and the part which the intestines play in the digestion of food was ascertained by them twenty-one hundred years before Pavlow published his discoveries to the medical world. More than two thousand years before Morgagni, the father of modern pathologic-anatomical research, the Rabbis enumerate one hundred and forty pathological conditions. While Galen still considers the thoracic cavity as filled with air and thinks such a condition necessary for normal breathing, the Rabbis of the Talmud say that a pneumothorax is fatal. At a time when the function of the brain and that of the spinal cord were but imperfectly understood, the Talmud considers the brain, which it describes as having two linings, a tender (pia mater) and a tough (dura mater) as being the seat of the rea-

soning faculties, while upon the integrity of the spinal cord depends all the movements of the body. The heart, in which the auricles and ventricles are described, is the organ upon which the life of all other bodily organs depends; the liver is the laboratory for blood, the pancreas is an accessory of the liver, and respiration is compared to the process of burning, so that expired air is incapable of sustaining life. The difference between the peritoneum and the extra-peritoneum is noted, and, contrary to the current opinion of the time, the blood vessels were filled, not with air (pneuma) but with blood (dam). Moreover, the danger of eating meat or drinking milk of tubercular animals is nowhere mentioned in the Greek writings, but the Talmud fully recognizes it. It even differentiates between tubercular caverns and bronchiolectasis, something that is not to be found in all literature before, nor at the time of the Talmud.

As regards infectious and contagious diseases, we know, of course, that the Bible already contains quarantine laws. The Talmud extends these much further and prohibits even the drinking of water that has been standing uncovered, unless it is first boiled, and warns against the nearness of flies to open wounds because of the danger of infection. In fact, surprising as it may seem, the Rabbis say that the air is full of invisible, harmful creatures which would make life unbearable if we could only see them all. (If they had only called these "microbes" instead of "shedim"!)

Our embryologists might be especially interested to know that their specialty attained to a high degree of knowledge and familiarity on the part of the ancient Rabbis. Aba Saul, with whom medicine was merely an avocation, his vocation being that of a grave digger, described minutely a fetus at the end of the sixth week. Rabbi Samuel, on the other hand, says that it is impossible to determine the sex of an embryo before the end of the fourth month, a theory which is held, I believe, by embryologists of our own time.

The high degree to which surgery had been developed by the Talmudic teachers, who guided the spirit of their people and guarded their health, may be seen both from the operations they performed and their modus operandi. They had specialists in this line who were known as "ummanim." The operating room is referred to as the "marble hall." A tunic was worn by the surgeon over his clothing; various instruments were used; the borders of old wounds were freshened up to effect a union, and, in major operations, an anesthetic (same de-shinta) was administered. Among the operations, dislocation of joints, fractures, amputations and trephining are frequently mentioned. Artificial teeth, made of hard wood, gold or silver, are also mentioned. The removal of the spleen, various forms of castration, intubation of the larynx and an operation for an imperforate anus in newborn are described. Cranial plates, uterine speculum, crutches and a variety of other orthopedic appliances were in use, and the Caesarean section was practiced.

That those Rabbis of old were thoroughly human, "even as you and I," may readily be inferred from the frequency with which they differed in their diagnosis of a given case and from the pertinacity with which they endeavored to prove the correctness of their respective opinions. One interesting instance of a difference of diagnosis is recorded in which a sheep dragged its hind legs. The malady had been differently diagnosed by different Rabbis. Rabina, however, contended that it was due to an injury or impairment of the spinal cord. The sheep was thereupon killed and an autopsy bore out the correctness of Rabina's diagnosis. This, by the way, is the first recorded case in which a diagnosis made upon a living object was verified upon autopsy of the same object.

All this may appear strange and surprising. What is most surprising, however, is that the Talmud formulates the principle that the symptom of any disease is merely the external manifestation of internal functional disturbances. This principle, which is today the prevailing teaching of pathology, is not even alluded to in the writings of Hippocrates and is only hinted at vaguely by Galen in his "De locis affectis."

In conclusion, it might be well to point out the fact also that the high regard which the Rabbis of the Talmud had for medicine and the high position which physicians occupied, did not make these insensible to their tremendous responsibilities and ethical obligations. The Talmud lays down the rule that "the service of a physician for which no fee is charged is not worth a fee." (This might profitably be printed in large type by modern doctors and hung in their waiting rooms.) Yet, a prayer, which one of the Talmudic doctors recited every morning before starting out on his round of duties, clearly indicates a deep sense of both humility and responsibility. The prayer, which has been preserved in the original, is as follows:

"All-kind! Thou has formed the body of man in full wisdom. Ten thousand times ten thousand tools Thou hast united within him, and these are unceasingly active to maintain the envelope of the immortal soul, this beautiful entirety, in harmony. Continually they are busy in complete order, agreement and accord. Whenever, however, this order is broken by the fragility of the matter and the untameness of the passions, the powers come into conflict with one another and the body falls into dust. Then Thou sendest man Thy merciful messengers, the diseases, and they tell him that danger is approaching, and they urge him to forfend it.

"Thine earth, Thy streams, Thy mountains Thou has blessed with such things as may bring remedy, and may mollify the pains of men and cure their ills.

"And Thou hast endowed man with wisdom so that he may relieve the body of ill, so that he may recognize order and disorder, so that he can discover the proportions of things and ascertain their functions and prepare against each evil that which may ameliorate or prevent it.

"Me also Thine eternal providence has chosen to watch over the life and health of Thy creatures. I am about to begin the exercise of my profession. Aid me, O All-kind One, in this great work, so that it may be of avail, for without Thine assistance nothing succeeds, not even the least.

"May the love of fellow-man and the love of my art ensoul me. May not thirst for gain nor craving for fame mingle in my service. For these are enemies of truth and charity, and they might mislead me and keep me from doing what I ought to do for the weal of my fellow-men.

"Preserve the strength of my body and of my soul, so that I might be unperturbably ready to help the rich and the poor, the good and the bad, the enemy and the friend. Let me see in the sick the man alone. Enlighten my understanding, that I may see what is before me and encompass it, and that I may surmise what is absent and detect what is hidden. Let my mind not sink, lest I fail to recognize what is visible and overrule it; lest, indeed, see what is not to be seen at all. For the limit in my art is lightly traced, and it comprises the health and life of men.

"May my mind be always on the alert. While I stand at the bedside let not alien things intervene to rob me of attentiveness, nor disturb me in my silent meditation, for great and holy are the searchings on which depend the weal and woe of Thy creatures.

"Grant that the sick have confidence in me and in my art, and that they heed my advice and orderings. Banish from their side all quacks and the host of counseling kindred, and of overwise nurses, for these

are cruel people, and pervert the best intentions and thwart those who are expert in the healing art, and they lead men to death.

"If wiser men wish to teach and correct me, may I follow them, and be grateful; for the compass of our art is large and wide. But if zealous fools upbraid me, then let the love of my art keep me strong, so that I may adhere to truth without regard to years and fame; for weakness and yielding would involve the pain and even the death of Thy creatures.

"Let me be patient and calm when older men of my profession, proud in the number of their years, crowd me out, or taunt me or offer jeeringly to better me. But let this, too, be for my improvement, for they know things that are forgotten to me; still let not their conceit grieve me. They are old, and old age is not master of the passions. I, too, hope to grow old upon the earth, before Thee, O All-good.

"Give me frugality beyond all, except in the great art. May never awaken in me the notion that I know enough, but give me strength and leisure and zeal to enlarge my knowledge and to attain ever to more. Our art is great, and the mind of man presses forward forever.

All-good! Thou hast chosen me, in Thy grace, to watch over the life and death of Thy creatures. I am about to go to my labor. Be with me in this great work, so that it may avail, for without Thy help nothing succeeds, not even the smallest."

DIATHERMY IN THE TREATMENT OF NEISSERIAN INFECTIONS OF WOMEN.*

H. W. E. WALTHER, M. D.,

NEW ORLEANS.

It is the opinion of many physicians that gonorrhea in the female is an incurable condition. Just why so pernicious a belief has become inculcated into the minds of so many medical men, I am at loss to explain. It is true that many female patients with gonorrhea retain their infections over an indefinite period. This state of affairs is due largely to ineffectual treatment or no treatment at all. Certainly the methods of diagnosis and of treatment, of this wide-spread malady, have appreciably advanced and the indictment that Neisserian infections cannot be cured must be refuted. At least, the urologist cannot permit this charge to go without challenge.

It should be emphasized that the vaginal douche and the medicated tampon have had their day as therapeutic agents directed at destroying the gonococcus in the female genitalia. More potent measures are demanded if we are to effectually combat this disease.

Despite the commendable work the American Social Hygiene Association has been doing, the incidence of gonorrhea in women has not decreased. We see just as much of these infections today as we have ever seen. True their efforts are not altogether in vain. As I see it, a very real benefit of their educational propaganda accrues from the bringing of unfortunate girls and young wives to physicians sufficiently early to prevent, or at least to minimize, serious complications to the tubes and ovaries.

The early recognition and the prompt application of efficient therapeutic measures is unquestionably doing much to prevent the possible extension of the diplococcus of Neisser to the most vital structures woman can boast of. And in bringing the treatment up to a plane where satisfaction in clinical results are daily becoming more evident, the urologist has played no small part. Studies on the prostate gland and seminal vesicles in the male, and the role they play in perpetuating infections, has done much to stimulate similar investigations in the female.

*Read by invitation before the South Mississippi Medical Society, at Laurel, Miss., March 10, 1927.

The gland structures are ever the haven for gonococcal perpetuation. In women this holds with as much emphasis as in men. If we can totally destroy the gonococci in Bartholin's glands, in Skene's glands and in the glands of the cervical canal we can feel assured that a real step forward has been made in eradicating the disease. The methods that have been advanced for accomplishing these ends are too numerous to mention here. Suffice it to say that ultimately we have come to *heat* in some form as being the one dependable agent.

Diathermy has proven itself the most efficient means of applying heat within the body tissues. It is not only eminently effectual but also the most easily controlled form of heat therapy. The technique of applying this modality of high frequency current is exacting but, with patience, can be acquired by any physician willing to sacrifice sufficient time in order to familiarize himself with the rudiments of the procedure.

BARTHOLINITIS.

At the external genitals of the female we encounter first the glands of Bartholin or the vulvovaginal glands as they are more commonly called. Situated in the lower and posterior portion of the labia majora, extending posteriorly to the triangular ligament, the ducts of these glands empty on the inner aspect of the labia minora and are easily recognized in disease. In my cases 40 per cent of patents with gonorrhea have these glands infected. When the ducts of these glands become stenosed abscess formation supervenes.

It has been the common practice to excise these glands with their accompanying ducts. Such procedure exposes lymph channels which might disseminate the infection rather than arrest it. The advent of surgical diathermy is truly a boon in such conditions. By the insertion of a blunt-tipped needle electrode into the duct, both the duct and the gland can be sterilized in a few seconds. The after care consists of topical applications of a 10 per cent mercurochrome solution.

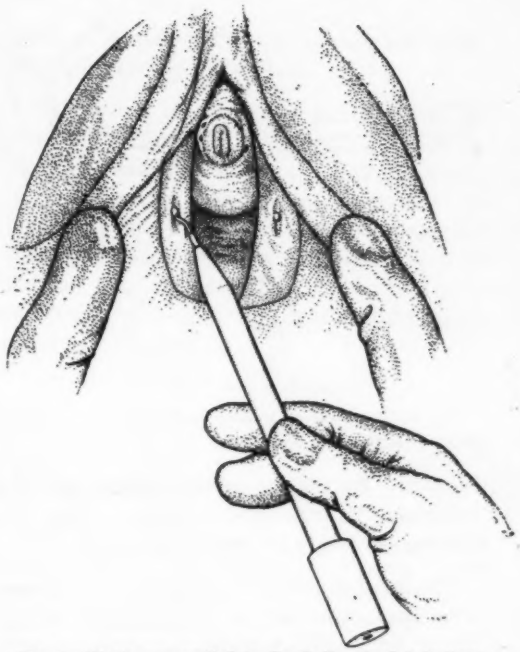

Fig. 1—Diathermy applied to Bartholin gland infections.

SKENITIS.

Situated on the urethral floor laterally and just within the external meatus are found two gland openings first described by Skene which extend upwards along the submucosal structure for from 4 to 12 mm. ending in blind pouches. Skenitis has occurred in 90 per cent of the women I have treated for Neisserian infections. While these are not the only glands found in the female urethra, they are the most important. Infections persist longest in the anterior third of the female urethra and this is attributable largely to Skene's glands.

The diathermic needle, employed through the electric skeneoscope is the most valuable agent of therapy. Usually one gland is treated at the time because of reactionary edema which follows high frequency cauterization here. Within three days or a week the other gland is sterilized in like

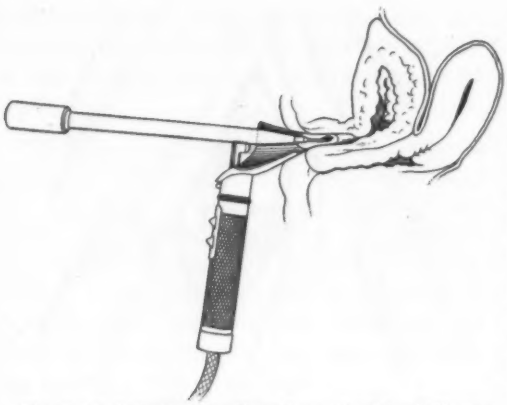

Fig. 2—Technique of treating Skene gland by diathermy through electric skeneoscope.

fashion. By the aid of local anesthesia, the treatment is rendered painless. The follow-up care is with mercurochrome.

Urethral stricture is common in women with these ailments so that routine dilatations, with silk bougies or steel sounds, occupy a most important role in winding-up the treatment to the urethra.

ENDOCERVICITIS.

Gonococcal infections of the cervix have attracted the attention of many investigators in gynecological urology if we can judge by the numerous articles which have appeared in the literature of the past few years. And although opinions differ as to the best mode of eradicating gonococci from the endocervical glands, all seem agreed that *heat* in some form offers the most lasting results.

When we consider that 80 per cent of all infected women contract endocervicitis and further when we remember that the glands are deeply situated in a structure that resists ordinary forms of therapy most obstinately it becomes necessary to adopt heroic measures. Sufficiently intense heat will kill organisms; that we know. We know too that by the aid of electrothermic high frequency we can obtain a high degree of heat, generated within the tissues, for a period sufficiently long to destroy bacteria and yet not injure the tissues treated.

Medical diathermy suggests itself as being eminently the agent of choice in handling these cases. Our favorable report on diathermy in endocervicitis, presented before the Southern Medical Association at Dallas in 1925, expresses our feeling at the present time. Since that tabulation of 38 cases, we have treated an additional series of 17 cases with the same encouraging results. Our technique differs from that of other workers in this field and I regret that time will not permit my going into the details essential for satisfactory results. To those sufficiently interested, I refer them to the original publication.

In concluding this most superficial survey of a very interesting topic, I would be remiss if I failed to emphasize some of the other factors that go towards making the handling of these cases more certain of success.

Physiological rest, a state most earnestly to be wished for in our patients but so seldom found practical, is really imperative for good results. Dancing, athletic sports, laborious house work and last, but by no means least, indulgence in sexual intercourse must be interdicted. Obviously, unless this later order is respected the results from the best possible treatment will be disappointing. Drinking of alcoholics is

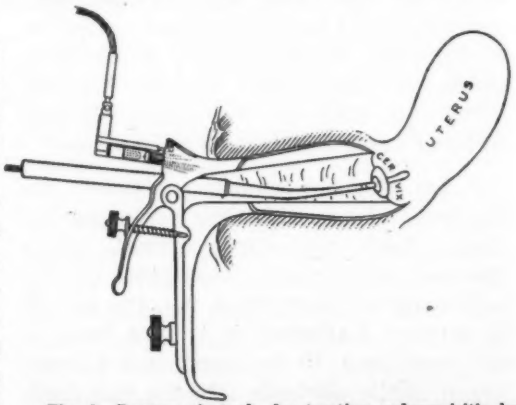

Fig. 3—Pessary electrode for treating endocervicitis by diathermy.

harmful to these patients for more reasons than one. The drinking liberally of water, proper attention to personal hygiene and the daily cleansing vaginal douche are to be encouraged. Vaccines and sera have proven a complete failure so far. Mercurochrome intravenously has helped me as an adjunct in certain refractive cases. Neoarsphenamin intravenously is employed in many instances with pleasing results. Just how either of these drugs help is not always clear. But they can do no harm, when administered in moderate sized doses, and are worthy of a trial.

Gonorrhea in women is curable and the means at hand for dispatching these infections promptly is here. Physiotherapy in the form of diathermy, though in its infancy, will yet play an important part in the minimizing of this dreaded scourge which has, for centuries, blighted the physical well-being of so many unfortunate girls and women.

1326 Whitney-Central Building.

A NEW URETHRAL SOUND.

CASSIUS L. PEACOCK, M. D.,

NEW ORLEANS.

This sound was designed primarily to meet the many difficulties in passing instruments of this type in the aged. In prostatectomized patients it was found that sounds and bougies produced considerable trauma at the bladder neck and in the prostatic cavity. To overcome this we had made a short curved end with large body gradually tapering to the handle. This eliminated the injury to the bladder, gave us maximum dilatation where most desired and prevented the unnecessary stretching at the meatus. The patient so often complains of suffering from the use of ordinary sounds which at times prevent proper manipulation in the posterior urethra. It was found later that the sound was very useful in dilating postoperative stricture of urethra where dense scar tissue had formed. The short curve passed more easily and no trouble was experienced in guiding it through the tight urethra. This led to its general use in all cases where sounds were indicated and with very satisfactory results. In the female urethra it has proven as satisfactory as in the male.

I do not wish to leave the impression that the sound described will replace the various models now in use but in certain pathological conditions, summarized below, it will be found far superior:

1. Prostatectomized patients;
2. Hypertrophy of prostate where operation is postponed;
3. Chronic posterior urethritis with tendency to stricture formation;
4. Massive cicatricial tissue formation of urethra following mutilation of urethrotome;
5. In female urethra; and,
6. Fistulous tracts.

Fig 1—Peacock sound.

The sound is twelve inches long, with small, flat handle, straight shaft and short curve tip or beak with rounded end. The tip measures 10 F. The curve is one-half inch long and gradually increases in size to the body which represents the size of sound, and is continuous for four inches. This tapers to the handle where it again measures 10 F. They are made of monal metal in sizes, 18-20-22-24-26-28 F., by I. L. Lyons & Co., Ltd., of New Orleans, and if desired can be obtained without curved tip.

1326 Whitney-Central Building.

Clinical meeting of the Medical Staff, Touro Infirmary, March 9th, 8 P.M. Meeting called to order by Chairman, Dr. A. I. Weil.

Dr. Harold A. Bloom presenting a paper on Hypopituitarism.

Dr. Harold Bloom: I am showing this case tonight, not that it is unusual but because of the satisfactory results we have had in the treatment.

Patient: C. N. Age 12 years. Complaint: Obesity.

Family history: Parents living and well. One sister in good health.

Present illness: Patient was perfectly normal until he reached the age of 8 or 9 years when he began to complain of headaches. Mother thought it was eye trouble and consulted an oculist, but nothing was found. Tonsils were not suspected when headaches continued and an otolaryngologist consulted. Patient continued to have headaches and increase in weight, A. B. M. R. was run and doctor gave gland extract by needle for six months with no improvement. (This was thyroid extract it seems from mother's history.) Condition continued to increase in severity until the child was brought to Touro Clinic.

Physical examination: Reveals a very obese boy, (weight 168 lbs.) short in stature, with a small head, small hands, dull, apathetic, temperature 98. Skin: smooth, soft, pale, and thin; fingers wide at proximal ends and tapering—marked prominence of both breasts, absence of hair on body. Pelvis: broad and feminine in type, marked girdle obesity and marked development of fat over body, showing infantile sexual organs.

No evidence of faulty skeletal development.

Laboratory findings: Wassermann negative. B. M. R. minus 37. Sugar tolerance increased.

X-ray of skull: Lateral view of skull shows a huge sella turcica but no erosions of its floor or destruction of anterior or posterior clinoid processes. No other evidence of pathology.

X-ray of long bones negative.

Blood:		
	R. B. C.	5,125.000
	Hgb.	80%
	C. W.	0.78
	W. B. C.	7,250
	S.	24
	L.	3
	N.	62
	E.	1
	B.	0

Urine: Light straw color.
Acid reaction.
Sp. gravity 1016.
Albumin, slight trace.
Sugar, negative.
Indican negative.
Acetone negative.
Diacetic acid negative. Microscopic negative.
Eye grounds negative.

Diagnosis of hyperpituitarism made.

Treatment: Was put on tablets of pituitary gland September 11, 1926. Weight, 168 lbs.

Weights as follows:			
	9-11	Weight	168 lbs.
	9-21	"	155 lbs.
	10-2	"	151 lbs.
	10-16	"	148¾ lbs
	10-26	"	146 lbs.
	11-9	"	140 lbs.
	11-30	"	135 lbs.
	12-14	"	128 lbs.
	1-26-27	"	122 lbs.

On Jan. 25th, diet was increased on account of patient having been sick. Tablets were continued.

February 1st, weight 120 lbs.—tablets stopped—diet same.

February 8th, weight 120 lbs.—no tablets—diet increased.

February 22nd, weight 119½ lbs.

March 2nd tablets gave out for four days—weight 117½ lbs.

March 8th, weight 117½ lbs.

Measurements	Previous to treatment	Present
Breast		30 inches
Waist	40 inches	31 inches
Thigh	30 inches	23 inches
Height	62 inches	63 inches

Sugar tolerance is now normal.

Basal Metabolic Rate:	Minus 37	Minus 16
Blood pressure	100	116
	40	80

This boy's teacher said that while he was behind in his work because of loss of time on account of his attendance on the clinic, they had reason to believe he is very much more interested in his work. He used to sit in class without being interested at all. (Patient shown.)

Dr. A. B. Pitkin: (discussing Dr. Bloom's case): This case is very interest-

ing because of the satisfactory result obtained; clinically, I do not think that it suggests one of pituitary deficiency. The patient had been on thyroid medication, previous to being seen by Dr. Bloom, without apparent result. During the course of treatment by Dr. Bloom he was given only pituitary medication. The loss of weight, diminishing of special fat deposits, and increase in height appear interesting. But the lack of sexual development and lack of hair appear to be normal at this age; as well as the increase in height noted in the length of time he has been observed. He has been on a diet which might account for the loss of weight. My experience with cases of marked dyspituitarism is that they were not benefited by pituitary medication by mouth. Dr. Barker demonstrated that the control of diabetes insipides, with pituitary substance could only be gotten when given hypodermically. When an interne here in 1920, I saw the same thing well demonstrated with a case which had been worked up thoroughly at Mayos. Again, this case does not present the slightest suggestion of prognathism nor has he spatula-like hands; the X-ray study of the bones was normal. I have found in basal metabolism work that when a checked reading proves to be minus 20% or lower, deficient thyroid secretion is the main factor in the case. Cases labeled "pituitary dyscrasia" in the main have shown a basal metabolic rate average of minus 12%. However, results count and the proof of the pudding is in the eating and Dr. Bloom is to be congratulated.

Dr. Von Meysenbug: I would like to ask Dr. Bloom if he made any changes in this little fellow's diet?

Dr. Bloom (answering Dr. Von Meysenbug's question): He lost weight so that we increased it. He had a tremendous appetite when he first came. No changes in the constituents of the diet.

Dr. Bloom: It is true that according to the X-ray, no skeletal changes were found. He had girdle obesity. It was really because of his infantile sexual organs that he was brought to me. I can stop the gland extract and leave the diet as it is and he will gain. About his sexual infantilism, he is just 12 years old and I do not expect to develop hair on his body yet. His sexual organs are larger than when he came.

Drs. Randolph Lyons and Urban Maes: Hypernephroma E. 685—45 E-22. Mr. S. P.

Dr. Lyons: This case, a man, age 65 years, admitted 1/26/27 and discharged 2/4/27, is, I think, of particular interest from my point of view because of the diagnosis. That was my chief interest in the case. He does present, however, a good many points of interest to others in different lines. I think he was very interesting to the radiologist, the neurologist, and last, but not least, to the surgeon. I saw this patient on January 18th, 1927. He came to the office complaining of shortness of breath, palpitation and weakness. Most of the past history has very little to do with the present condition. He has always been in practically good health until ten years ago when he was told he had high blood pressure. At the same time he was told he had albumin and casts in the urine. The blood pressure varied from 200 to 165 diastolic. The urine has continuously shown traces of albumin and casts. In May, 1926, he had an attack of so-called grippe. It must have been a very complicated attack because he was sent to the hospital. He had chills and fever and the leucocyte count was practically normal, between 6000 and 9000. They thought he might have an abscess of his liver. Summary of the examinations made there was that he probably had grippe and while the examinations were being made, he had an uneventful convalescence.

When he came to my office on January 18th, I thought he was suffering from a myocardial condition. No edema, pulse rate rapid. He had been quite weak since another attack of grippe in December. The difficulty in diagnosis in this case came from the fact that he was an unusually large man and had an unusually large chest and abdomen. When I saw him in the office, I felt a mass which I thought was an enlarged liver. Blood pressure at that time was $\frac{170}{90}$. The heart was enlarged somewhat to the left but seemed to be pushed up by enormous gas bubble in the stomach. He had high blood pressure for a good many years. I put him to bed for 3 or 4 days. Under some purgation and rest, the pulse rate came down and then I made out a very large mass in the right flank, down almost to the pelvis, but it did not extend beyond the median line. Another thing noticeable

was the fact that between this mass and the costal margin I could feel what I thought was the transverse colon. On making him stand up the mass protruded out to the right, a fact which he himself noted. He was running a slight temperature. Stools negative for amoeba. We brought him to Touro on January 22nd for further examination. We tried to rule out liver and to do that we had a blood chemistry made which was normal except for high uric acid. Liver function tests were normal and Ehrlich's aldehyde test of the urine negative. We then had some x-rays taken and the x-ray did not show the liver shadow to be enlarged upward and it showed the presence of the transverse colon in its normal position. At this time, I asked Dr. Maes to see the patient and see what he thought of this mass. He was inclined to think that the mass was a liver abscess and on that basis, aspirated it several times without finding any pus. I am going to ask Dr. Reed to tell us about the cystoscopic examinations and pyelograms. I might add that the urological examinations showed the mass to be a large kidney tumor. The apparent difficulty in diagnosing an enormous growth whether kidney or liver was due to the enormous size of the abdomen.

Dr. Reed: Almost all cases of renal tumors give some signs long before the case comes to the surgeon, in that they show blood in the urine—either in microscopic or macroscopic quantities long before any other symptoms occur. This particular case was one of the biggest tumors I ever saw. It weighed 4½ lbs. The first pyelogram that was made was unsatisfactory, due to the fact that a very weak solution of sodium iodide was used in order to avoid any more reaction than necessary. The second pyelogram was made with a much stronger solution and gave us a picture that resembled a long tree with several branches attached to it. I have had the pleasure of studying, recently, three cases of renal tumor, all of which showed definite urinary findings, but had little or no other symptoms such as pains, loss of weight, fever, etc. It was only because of the microscopic or macroscopic blood that was found in the urine that they were sent to me for examination. Any individual showing blood in the urine at the age of 35 or 40 years should by all means be thoroughly studied before a diagnosis is made.

Dr. Lanford: The histology of neoplasms that spring from the adrenal organ varies considerably depending on the particular portion of the structure that the parent cell arose from. They vary too in their invasive characteristics and their probability of metastasizing. This particular neoplasm was a low grade form of malignancy. The cells apparently came from the reticular zone of the adrenals and were practically all adult in character. The histology is borne out by the findings at operation in that the tumor was not invasive, it being apparently growing almost entirely in an expansile manner such as benign neoplasms grow. It is difficult too to say how long the neoplasm was present before it was discovered but, due to the extensiveness, it had no doubt been present for a good long time. That fact also speaks for a low grade form of malignancy, as had it been rapidly growing, it would have shown more infiltrative characteristics and no doubt secondary growths elsewhere would have made their appearance.

Dr. Levin: Dr. Reed did not mention whether the phthalein test from each kidney would reveal disease of the kidney before operation.

Dr. Reed: There is always a marked diminution of phthalein excretion from the kidney involved. The amount depends on the actual involvement of the kidney.

Dr. Lyons: We did not have a report on phthalein. The report that we did have was that it was very little. Another striking thing was the relatively few symptoms with the enormous tumor. We might compare it with a large woman carrying a baby without symptoms.

Dr. Rudolph Matas presented notes on seven cases of giant elephantiasic pendulous tumors of mixed types, chiefly lymphoneurolipomatous fibromata of Recklinghausen's disease, to accompany a lantern slide exhibit showing the peculiarities of the individual cases.

Miss V. T., Marrero, La. (145-C-388 L-720). Native of Louisiana, age 38 years, applied to the Touro Out-door Clinic for relief of an enormous tumor which had made its appearance as a noticeable growth on the back and lower dorsal region, when the patient was six years old. It probably had appeared before this, but no serious attention had been given it. (The growth and many smaller tumors [molusca] became more numerous and larger as she grew older.) When she was ten years old, the mollusca, or tumors, had spread like an eruption over her entire body, except the face, hands and arms. These tumors varied in size from a small dried grape, or raisin, to that of a small tangerine orange. The majority of these remained stationary, but the growth in the back grew larger continuously, until it hung from her back as an immense bag of flesh, which rolled over her buttocks and thighs, and stretched below her knees and ankles when she stood up. The tumor was held to the body by a very broad pedicle which involved the entire lumbar region and stretched from it to the thorax and epigastrium in front, where it merged with a large area of dark, heavily pigmented skin which contracted into numerous rugae when allowed to relax.

The very traction of the growth, as it hung from her back when standing, seemed to increase the size through a secondary oedema. It gradually impeded her locomotion. In spite of which she continued to work as a laborer, until the last two years, when the drag of the mass was so great that she had to go to bed, utterly disabled and weakened by demands that the tumor was making upon her nutrition and general health. It was in this condition that her people decided, upon advice of the family physician, to bring her to Touro Infirmary with the hope that something could be done for her relief.

She was admitted to the Surgical Free Ward, Touro Infirmary, on January 27th, 1927, and was kept under observation from that day to February 18th, in all twenty-three days, during which time she was kept in bed, with the hope that by preoperative general and tonic treatment, she would be prepared for the formidable operation that would be required to free her from the burden of this giant mass. It was with much dread and misgiving as to the outcome, that final preparations (strychnine, digitalis and stimulating liquids) were made on February 16th and 17th for the operation which was performed at 11 A. M. on Feb. 18th.

On the day before the operation the patient weighed 170½ lbs.—the tumor was estimated to weigh 60 pounds, and after deducting the tumor weight, her weight would approximate 110½ lbs. Her blood pressure at this time registered between 126/74 and 127/77—pulse 80-90 and respiration 20.

Bloods—Reds 4,455,000	Whites 5,750
Hemoglobin 65%	Eosinophiles 5%
Small mono 27%	Large Mono 3%

Urine, acid—1026 and negative for all abnormalities.

Only a low hemoglobin and moderate red count to contra-indicate the operation. The pre-operative problem in this case, was how to avoid hemorrhage and prevent shock. To obtain prophylactic hemostasis I had planned to have made two large pairs of long extemporized metal clamps which would compress the broad pedicle, and permit a sharp amputing knife to sever the pedicle between them. This plan was not deemed feasible, owing to the great irregularity and vast breadth of the fold of skin that attached the tumor to the body. Instead of these giant clamps, it was decided to transfix the base of the pedicle with two strong Wyeth pins, and to constrict the neck of the tumor with a tourniquet made of three and a half yards of long rubber tubing. Before constricting the pedicle, it was also decided to drain the tumor of the large amount of blood, which it no doubt contained, by suspending it over patient's back with a pair of ice tongs, suspended from a pulley in the ceiling. After draining it of blood, while under the anesthetic, and helping to exsanguinate it by manual compression and massage, the constrictor was to be applied.

This procedure was carried into effect immediately after the patient had been anesthetized with ethylene-oxygen gas by Dr. Baker. The tumor was hooked to the tongs and suspended high above the level of the patient while she was lying in the left lateral decubitus.

After waiting about fifteen minutes, during which antiseptic preparation of the skin was made, the pedicle was transfixed with the Wyeth pins and the circular rubber constrictor tightly wound around the neck of the tumor, where it was held in place and prevented from slipping by the pins.

The immense pedicle was not cut across with an amputating knife and large scissors, leaving a cuff of skin about two and a half inches below the constrictor. While this division was proceeding, the large veins, arteries and lymphatics which were involved at every step, were secured with prophylactic clamps. But, even with all these precautions, the amount of clear serum, or lymph, that poured out of the divided tissues was extraordinary. It was a real lymphatic hemorrhage; the clear lymph pouring out of the cut surfaces in streams, that must have amounted to several pints.

After this tumor had been detached, all the veins held in the hemostate were immediately ligated—fully fifty to sixty (50-60) ligatures being required to secure the clamped veins. The clamps on the tumor side were allowed to remain on the tumor. Having apparently secured all the vessels that were recognizable, the tourniquet was gradually removed and a number of bleeding points, not previously recognized, were secured. Finally, after the pins were removed and the full extent of the divided tumor attachment was exposed, it was found that the exposed area left by the amputation, extended from the level of the 10th rib posteriorly, downward and obliquely, forwards over the spine to the 9th dorsal cartilage, in front and middle of the right lumbar region, to the mid-right iliac crest.

The incisional wound was fully twenty-eight (28) inches in length. Fortunately, the skin edges were easily approximated, owing to atrophy and elasticity of the skin on the abdominal side which formed dermolytic and relaxed folds.

Before closing the incision, a large, hard, encysted fibromatous mass which extended from the lower angle of the left scapula to the level of the pedicle, was dissected and partly enucleated out of its bed in the aponeurosis of the deep dorsal muscles. This mass seemed to be made of solid, hard and fibrous tissues, corresponding in description of these secondary growths to the acrochrondroma, mentioned by some authors (Taylor, Jnl. Cutn. Disease, 1887).

Notwithstanding its immense size, no drainage was left in the wound, excepting potential drainage obtained by long interspaces allowed between sutures which were considered sufficient to allow the serum to escape.

It is interesting to note, that the patient's condition gave no cause for alarm during the operation, until the pedicle was cut and the mass was severed from the body. Up to this stage, the anesthetist's chart showed that the pulse and respiration were regular and not materially affected by the manoeuver, but when the tourquinet was removed, the pulse immediately climbed to 160 and the blood pressure fell to $\frac{130}{90}$ to $\frac{80}{?}$.

This contingency had been feared and before this had occurred, the interne had the cannula inserted in the left bacillic vein and a hot 5% glucose intravenous infusion was begun. This immediately improved the situation—the pulse rate falling at once and the blood pressure rising sufficiently to allow the operation to continue without interruption to its final completion. The patient was then well wrapped up and warmed, and sent to the ward in very fair condition.

After her return to the ward, the intraveonus infusion was continued as a drip to which adrenalin solution was added, at regular intervals with digalen and strychnine. Though the usual morphia hypodermic had been given as a preliminary, before the operation had begun, it was again given after the patient had been returned to bed. She was also given fluids quite freely by mouth as there was little nausea or vomiting.

The patient was quiet and apparently comfortable until 2:30 P. M. She slept most of the time, but spoke intelligently at intervals. Under the influence of the drip, digalen and laparotomy tablet, with warming of the body, the pulse fell to 120, respiration 22, and was at this level until 2:30 P. M., when a sudden decided change occurred. The pulse rose then to 152, respiration 24 plus, and then the pressure fell, so that the pulse was scarcely perceptible. The infusion was increased 2,000 c.cs. and more adenalin and morphia given, the patient immediately began to rally.

At 4 P. M. (four hours after the return of the patient to the ward) the pulse had gone down to 128, respiration 20—four ounces of urine was voided, and the skin was warm and moist. The pulse was of good volume and the patient rested quietly and comfortably. At 5 P. M. the cannula became obstructed and with the stoppage of the drip, the pulse again became very rapid and lost all volume, until it could scarcely be counted. The cannula was now reintroduced by an interne and with the return of the drip, the patient's general condition again improved.

At 7 P. M. she was comfortable, resting quietly, pulse 124, respiration 19. At 9:45 P. M. the cannula again became blocked and the pulse immediately weakened and did not improve until Dr. Landry reintroduced it in another vein—again the patient rallied. She continued to improve during the night and was progressing encouragingly, until 1 a. m. when she became restless and weak, extremities cold, temperature low.

The drip was concerted into a steady, full, infusion with adrenalin and by 6 A. M. the pulse was 120 and of fair volume, but the face and extremities were cold. The patient now refused to take fluid by mouth, complaining of nausea, but did not vomit. The drainage from the wound was sufficient to stain the dressings, but was chiefly sero-sanguinous and not bloody enough to cause her depression.

At 7 A. M. the pulse was 124, respiration 16, but the patient was very restless, and complained of a general uncontrollable itching which was attributed to morphia. As she refused to drink, a duodenal tube was inserted through the nose, and fluid given by this route. The tube was

passed with great difficulty caused by the presence of a large pharyngeal tonsil which obstructed the naso-pharynx.

At 10:30 A. M. the cannula pulled out of the arm and the vein for the third time became blocked by thrombus. Preparation for transfusion had been made and several members of the family were typed, but all seemed more or less incompatable. The pulse became faintly perceptible. The fluids introduced through the stomach tube were being absorbed, when the respiration became labored. By 8 P. M. rales and gurgling in the trachea were heard and it was evident that the patient had developed an oedema of the lungs and at 8:30 p. m. she ceased to breathe.

THE EYES AND MOTION PICTURES.

"Motion picture theatres are too dark," Guy A. Henry, of New York, General-Director of the Eye Sight Conservation Council of America, declared in a statement made public yesterday. "People are unnecessarily subjected to eye strain," he asserted, "in poorly lighted auditoriums."

Investigations reveal that managers of motion picture theatres have no method of determining the effectiveness of the lighting, said Mr. Henry, who urged the framing of a special code of illumination for motion picture auditoriums, following a scientific study of the problem.

"The human eye does not function to its best advantage in the dark or in looking at a fairly well illuminated object when the eye itself is surrounded by darkness," according to Mr. Henry. "There should prevail as high a degree of general illumination as may be consistent with securing clear and easy vision of the picture.

"Too low illumination causes dilation of the pupil to an abnormal degree and provides a coreal area which does not permit of focal accuracy and which tends to distortion of outline. To partially overcome this, segmental action of the ciliary muscle governing the focusing of the eye is induced. Such muscular action can be attained only by great effort.

"There is also strain of the iris muscle resulting from the prolonged dilation of the pupil and another objection is that the varying intensity of the light reflected from the screen requires constant iris action more difficult of accomplishment than under normal dilation.

"There is constant conflict between the extreme darkness surrounding the eye and the light reflected from the screen. Under such a condition the eye is not only more susceptible to the natural varying intensity of the light from the screen, but the adaptability of the eye is lowered and the slightest flicker or movement is more noticeable and deterimental.

"The illumination of the auditorium should be gradually reduced from the rear to the front and all light sources so modified as to prevent glare, especially those which may fall within the spectator's range of vision. A faulty shade leaking a little light in the orchestra or over the organ will be a source of annoying glare for even though the intensity of the reflected light from the screen may be much greater, the direct light by reason of the dark background will by contrast be blinding in effect and harmful to the eye.

"The decorative scheme of the auditorium naturally effects the general illumination. Gilt and silver even in subdued light may produce annoying reflections and, in some instances, these are responsible for an unfortunately low degree of lighting.

"At intermissions or changes in program when the general illumination is turned on the current should be carefully gauged and the auditorium gradually brought from a state of semi-darkness to full light. A sudden or too rapid turning on of light is not only irritating but may be decidedly harmful to the eyes.

"Investigations reveal that managers of motion pictures have no scientific way of determining whether or not the general illumination of the auditorium is what it should be and, in fact, this is governed by the judgment of the management which may take into consideration certain factors and entirely disregard others of equal or greater importance.

"A scientific study should be made of this problem and standards of illumination established for the guidance of the managers so that they may be sure that a matter so important as the general illumination of the theatre during the showing of the picture is scientifically correct and that the eyes of their patrons are not being subjected to strain.

"In fact there should be developed a special code of illumination for motion picture auditoriums which will cover a field, which is too important to be left to the judgment of individuals."

NEW ORLEANS
Medical and Surgical Journal

Established 1844

Published by the Louisiana State Medical Society under the jurisdiction of the following named Journal Committee:

A. A. Herold, M. D., *Ex-Officio*
For three years, H. B. Gessner, M. D., *Chairman*
For two years, Paul J. Gelpi, M. D., Lucien A. Ledoux, M. D.
For one year, H. W. Kostmayer, M. D., *Secretary;* Oscar Dowling, M. D.

EDITORIAL STAFF

H. W. E. Walther, M. D.—*Editor*
H. Theodore Simon, M. D.—*Associate Editor*
J. S. Ullman, M. D.—*Associate Editor*
Paul T. Talbot, M. D.—*General Manager*

COLLABORATORS—COUNCILORS

For Louisiana	*For Mississippi*
H. E. Bernadas, M. D.	J. W. Lucas, M. D.
F. M. Johns, M. D.	D. W. Coker, M. D.
F. T. Gouaux, M. D.	M. W. Robertson, M. D.
S. C. Barrow, M. D.	T. W. Holmes, M. D.
F. C. Bennett, M. D.	D. W. Jones, M. D.
C. A. Weiss, M. D.	W. G. Gill, M. D.
D. C. Iles, M. D.	E. M. Gavin, M. D.
G. M. G. Stafford, M. D.	W. H. Frizell, M. D.
	S. B. McIlwain, M. D.

SUBSCRIPTION TERMS: $3.00 per year in advance, postage paid, for the United States; $3.50 per year for all foreign countries belonging to the Postal Union.

News material for publication should be received not later than the twentieth of the month preceding publication. Orders for reprints must be sent in duplicate when returning galley proof.

THE JOURNAL *does not hold itself responsible for statements made by any contributor.*

Manuscripts should be addressed to the Editor, 1326 Whitney-Central Bldg., New Orleans, La.

LOUISIANA MEDICAL RELIEF IN DISASTER.

It is with a great deal of feeling and regret that we are presently recording throughout the Mississippi Valley the greatest flood of its kind in the history of our country. This has resulted in a great devastation of our State, calling upon our citizens for heroism and sacrifices unprecedented.

Following the plan of the American Medical Association for the organization of the medical profession for medical relief in disaster, the House of Delegates of the Louisiana State Medical Society in their recent session affirmed their belief in this principle, and asked the various Parish Medical Societies throughout the State to organize and be prepared for any emergency. This is very timely and is to be commended.

All classes of citizens have been made to feel the pangs of this disaster. The physicians of Louisiana as loyal citizens and in keeping with their professional obligations, have responded nobly to this test, thus maintaining the high reputation of the profession in the State of Louisiana.

While the response for medical aid and co-operation with allied medical organizations has been generous by necessity of the acute conditions, there will be a great deal of work to be accomplished after the waters have subsided that will keep busy our public health activities, boards of health and etc. This will be essential to keep out epidemics which if unabated would further add to the depopulation of our State. It is therefore in keeping that our profession and our progressive physicians of the State lend their co-operation, support and activities to all medical organizations and activities looking toward the preservation of health and the prevention of epidemic diseases as a result of the stagnant flood waters and the concentration of people.

The rehabilitation of our State is going to be slow. This will take us into months of the summer. Precautions should be taken against those diseases which go hand in hand with bad drainage and polluted water, such as malaria, typhoid, dysentery, and various forms of gastro-enteric disorders. It is going to necessitate the close application and functioning of all of our health agencies in co-operation with the profession throughout the parishes to mediate against the losses through illness and disability. The medical profession will be called upon to continue their co-operation and assistance until all dangers are entirely removed.

In this regard it is noteworthy that the recent military experiences of many of our physicians in the Medical Reserve Corps of

the United States Army will be a valuable asset and serve as an aid in developing and establishing proper medical supervision throughout our State.

DR. FREDERICK WILLIAM PARHAM.

Dr. Frederick William Parham was born at New Orleans, March 20th, 1856. He was the son of John Greenway Parham and Mary E. Blunt. He was a graduate of the Randolph Macon College of Virginia and received his medical education at the University of Louisiana, now Tulane University, having done Post-Graduate work in Philadelphia and having supplemented this with work abroad in European clinics, where he studied on such men as Czerny, Bramann, Hahn and Ewald. In 1887 he was admitted by competitive examination to the Charity Hospital, where he served as Interne with distinction for two years, notably during the malignant epidemic of yellow fever of 1878. From that time until his death his interest in the Charity Hospital never faltered and whenever he felt it necessary he worked untiringly for the betterment of its administration. This active interest throughout a period of fifty years was invaluable to the Institution.

Dr. Parham was Assistant House Surgeon of the Charity Hospital from 1885 to 1887, and one of his brilliant accomplishments was the inauguration and execution of a system of antiseptic and aseptic methods which practically eliminated the fearful mortality caused by puerperal fever in the maternity wards.

He recognized the great lessons of Pasteur and of Lister, and when the means were not available for carrying out the teachings of these men he installed in his ward at Charity Hospital his own sterilizer and carried out in the same wards aseptic operations. It was through these demonstrations that he convinced the staff of the value of such aseptic procedure. It is hard to realize, in this aseptic age of surgery, that it ever required the efforts of great leaders to prove to the community the worth of such teachings, but at that time one of the surgeons prominent in the medical profession is known to have said that he would have then practiced aseptic surgery, but it was too much trouble, showing that its value was not fully appreciated at the time of Dr. Parham's pioneer efforts.

Other pioneer work of this great surgeon was in chest surgery, he being one of the first in this country to attempt extensive work in malignant growths of the thoracic wall.

Dr. Parham was very active in organized medicine, having been President of the Southern Surgical and Gynecological Association, Vice-President of the American Surgical Association, President of the Louisiana State Medical Association, and President of the Orleans Parish Medical Society. One recent achievement of his was the organization of the Visiting Staff of the Charity Hospital of Louisiana. This was accomplished by him almost single handed; he realized the great value that would redound to the patients as well as to the administration of the Hospital by such organization. He served as President of the Staff for one year. He was a member of many societies, being a Fellow of the International Society of Surgery, of the American Surgical Association; of the American College of Surgeons, having been a member of the Board of Regents of that College from 1920 to 1925; member of the Southern Surgical and Gynecological Association, of the Louisiana State Medical Association, and of the Orleans Parish Medical Society. He held a commission as Major in the Reserve Corps of the United States Army and served as Chairman of the Medical Advisors of the Draft Board during the World War. Up to the time of his death he was Chief of one of the two surgical divisions of Touro Infirmary and Consulting Surgeon on the Staff of Charity Hospital. Dr. Parham was Dean of the first school for training nurses established in New Orleans.

He has contributed many original essays, observations and devices which have enriched the literature and won for him a national and international reputation. Among many notable contributions to the literature may be mentioned articles on "Resection of the Thoracic Wall for Tumor"; "Vesico Intestinal Fistulae"; "Operations for Inaccessible Vesico Vaginal Fistulae"; "Treatment of Hypospadies"; "Head Injuries Marked by Intracranial Tension"; "Some Practical Problems in Intestinal Obstruction"; and numerous other articles. He is internationally known for his original work in the surgery of bones, one of his latest contributions to this field being the Parham and Martin band, devised for the treatment of oblique fractures of bone.

As Professor of General and Abdominal Surgery in the Post Graduate School of Tulane University he was a recognized authority on surgery. It was to this university that he devoted much time and thought, having served as a member of the Board of Administrators from 1906 to 1914 and from 1925 until his death. His many years of service as Chairman of the Medical Advisory Committee of the Board stand pre-eminently as a model of conscientious and intelligent devotion to the highest interests of the School of Medicine and to the University. During his tenure of office many of the great reforms which have characterized the history of the School on medicine in later years have been effected. Recognizing "his services and achievements as a great and learned surgeon, as a medical leader, educator, administrator and public spirited and self-sacrificing citizen—and more particularly the example set by his personal character, his absolute honesty, his conscientiousness in the discharge of his professional and public duties his moral courage and his unapproachable integrity," — Tulane University of Louisiana conferred upon him the degree of Doctor of Laws in June, 1925.

He loved science, as in science could be found some relief for human suffering, and he directed his best efforts to the study of methods for its alleviation. In reviewing his life one is reminded of one of his addresses in which the following lines occur: 'For love is the thing that makes you care for the fate of this great round world. Ever'ything that exalts life, makes possible unselfish devotion, inspires to great heroism and wins the utmost triumphs of art, has love at its root. 'He loved his fellow men' is the greatest enconium that one could wish at the end of a long life."

He was a jealous of the good name of his profession. When he detected anything that challenged that good name, or the integrity of a fellow physician, he would combat it with boldness and with a vigor that derived its force from an impregnable rectitude. The entire life of this great surgeon has been "To strive, to seek, to find, and not to yield."

It is with deep regret that the *Journal* announces his death which occurred on May 6, 1927.

CORRESPONDENCE.

April 18, 1927.

Doctor H. W. E. Walther, Editor,
New Orleans Medical and Surgical Journal,
1551 Canal Street,
New Orleans, Louisiana.

My Dear Doctor Walther:

Would you mind stating in your publication that we should be glad to supply a copy of the "Preliminary Report of the Commission on Medical Education" to any of your readers who may be interested in the general questions of medical education and practice? We should be glad to supply these copies without charge, and anyone desiring a copy of the report can obtain it by addressing

Commission on Medical Education,
215 Whitney Avenue,
New Haven, Connecticut.

Sincerely yours,

W. C. RAPPLEYE, M. D.

Lexington, Miss., 4/28/27.

The Editor, Medical and Surgical Journal,
New Orleans.

Dear Doctor:

Because of the rarity of the condition in this country, I am reporting a case of sclerema, or the scleremoedema of Saltman.

An infant negro male, in the third week, history of swelling beginning in feet four days ago, and extending up the limbs until the genitals as well as abdomen were involved.

On examination found well developed baby, practically unconscious, having refused food for twelve hours; respirations superficial, skin dry and cool, temperature in rectum 94°. Rales throughout lungs. Skin oedematous and swollen from feet up, face slightly swollen, slight pitting, but soon disappeared, brownish colored spots on both feet, pupils contracted and would not react to light, kidneys and bowels both acting apparently normally.

From history of syphilitic history of father made diagnosis of sclerema, resulting from congenital syphilis. Made unfavorable prognosis, child died that night.

Yours fraternally,

R. M. STEPHENSON, M. D.

JUVENILE DELINQUENCY AND DEFECTIVE EYESIGHT.

Defective eyesight contributes to Juvenile delinquency, according to Guy A. Henry, General Director of the Eyesight Conservation Council of America, who in a statement today urges parents on Child Health Day, May 1st, to consider the vision of their girls and boys.

Child Health Day, general observance of which has been asked in proclamations by Mayors of cities and other officials throughout the country, should be made an event of moral and physical significance in every household where there are children, declared Mr. Henry, who is directing a nationwide campaign for better vision in education and industry.

Investigation by the Eye Sight Council, Mr. Henry asserted, has shown that "bad eyes make bad boys," and that the experience of Juvenile Courts prove that defective vision makes children truants. Each year more than 200,000 children come before these courts, and eye conservation in the home and in the school, according to Mr. Henry, should be employed as a factor in checking criminal tendencies.

"Juvenile Courts," Mr. Henry continued, "are finding that bad eyesight leads to inattention in school, to unfair competition, and to disrespect for authority. Bad eyes lead to truancy and the truant child is a criminal in embryo."

"Seventy-five per cent of all adult offenders start as criminals before they are twenty-one years old, and progress from petty to capital crimes is rapid. Parents must try to understand their children, for with understanding comes the explanation of wayward tendencies, which if uncorrected may develop unfortunate consequences even in the best of children.

"It has already been demonstrated that fully twenty-five per cent of the 24,000,000 school children of this country are suffering from manifest defective vision, and this situation is likely to grow worse if practical steps, with parents and teachers co-operatng, are not taken. Much has been done by the Eye Sight Conservation Council in the schools of the country, and much more will be done in the future, but lasting results are impossible without the aid of the home.

"It seems evident, from a general review of the entire subject of eyesight conservation, that approximately twenty-five per cent of all school children in the United States are retarded in their studies and that fully one-third of the retardations are in all probability due to defective vision.

"If this is correct, there are at least 2,000,000 school children in the United States one or more grades behind in their studies because of defective vision. The annual loss of retardation due to this cause alone is about $130,000,000.

"Child health—mental and physical—should be of paramount significance on May 1st."

TRANSACTIONS OF ORLEANS PARISH MEDICAL SOCIETY

During the month of May the Board of Directors has held one meeting and the Society two regular Scientific Meetings.

Miss M. L. Marshall, Assistant Librarian, has been sent to Washington to attend the Annual Convention of the Medical Library Association.

The books of the Society have been audited by Mr. L. L. Jarreau, public auditor, and this report is published in detail in this issue of the Journal.

In accordance with the plan of the American Medical Association for relief in disaster which was approved by us last spring, this Society following the request of the local Chapter of the American Red Cross through its Medical Chairman, Dr. Frank J. Chalaron, has formulated a complete plan of organization for medical relief in the Parish of Orleans and the adjacent Parish of Jefferson in case disaster were to befall during the prevailing flood condition.

The By-Laws have been completely revised and the changes in the Constitution have been voted upon. The revised copies of same will be sent to each member as soon as it is published in booklet form.

The Scientific Programs at the two regular Scientific Meetings are as follows:

May 9th.

"The Banana as a Food for Infants and Children"
By.....Dr. Ludo von Meysenbug

"Chronic Barbitol Poisoning"
By.....Dr. E. McC. Connely
Discussed by Dr. Walter J. Otis

"The Reduction of High Blood Pressure by a New, Original Method"
.....By Dr. Adolph Henriques

May 23rd.

"Extensive Colonic Polyposis with Report of Three Cases"
By.....Dr. A. L. Levin
Discussed by Dr. Sidney K. Simon

"Some Points in the Management of Labor"
By.....Dr. Elliott Kiblinger

"The Determination of Pathology in the Fallopian Tubes by the Injection of Lipiodol"
By.....Dr. Hilliard E. Miller and Dr. W. F. Henderson

We regret to report the death in the past month of Dr. F. W. Parham, Dr. P. B. McCutcheon and Dr. Florena G. Rich.

The following Doctors have been elected to membership: Active Member, Dr. Geo. L. Hardin; Associate Member, Dr. Hugo Popkin, and Interne Member, Dr. Wm. H. Roeling.

Dr. J. E. Doussan was reinstated to Active Membership.

The Membership of the Society to date is 487.

REPORT OF TREASURER.

Actual Book Balance 3/31/27	$5,042.66
Receipts during April	925.79
	$5,968.45
Expenditures	$1,638.02
Actual Book Balance	$4,330.43
Outstanding checks	388.00
	$4,718.43
Receipts since Bank Balance	$ 8.65
Bank Balance 4/28/27	$4,509.78

REPORT OF LIBRARIAN.

The reference work immediately preceding the State Meeting has caused the constant use of the Library during April. Four bibliographies have been prepared and added to our files on subjects as follows:

Dislocation of Carpal Bones (Semilunar) 1920-26.

Polyposis of Colon, 1917-date.

Bibliography of Dr. H. A. Royster, 1912-26.

Diagnosis of Intrathoracic Tumors, 1922-date.

Gifts have been received during the month from Dr. Lanford, Library of the Leland Stanford University Medical School, Library of the Medical School of University of California, and the Library of the Medical Department of the University of Minnesota.

55 books were added during the month. Of these 30 were received by binding, 6 by gift, 7 by exchange, 1 by purchase and 11 from the New Orleans Medical and Surgical Journal. A notation of titles of recent date is attached.

NEW BOOKS.

Surgery, Gynecology and Obstetrics Index v. 1-40, 1927.

Zinsser—Textbook of Bacteriology. 6th ed. 1927.

Crossen—Diseases of Women. 6th ed. 1925.

Rosenau—Preventive medicine and hygiene. 5th ed. 1927.

Sachs—Normal Child. 1926.

Dodds & Dickens—Chemical and Physiological Properties of the Internal Secretions. 1925.

Wood & Rowell—Health Supervision and the Medical Inspection of Schools. 1926.

Bethea — Materia Medica and Prescription Writing. 4th ed. 1926.

Williams—Obesity. 1926.

Gilchrist—Outlines of common skin diseases. 1927.

Bast—Life and Times of Adolf Kussmaul. 1926.

Pancoast & Pendergradd—Pneumoconiosis (silicosis). 1926.

A. M. A.—Hospital Service in the U. S. 1927.

Young and others—Studies on the Kahn precipitation test. 1925.

Rockefeller Foundation—Methods and Problems of education. 1927.

Sherman — Physicians' Manual of Vaccine Therapy. 1924.

Jour. Med. Research—Index v. 31-44. 1925.

Eberhardt—High Frequency Currents. 1915.

Berry—Orthopedic Surgery for Nurses. 1924.

McGuire—Profit and loss account of modern medicine. 1915.

H. THEODORE SIMON, M. D.,
Secretary.

Report of the Examination of the Books and Accounts of the Orleans Parish Medical Society.

New Orleans, La., April 20th, 1927.

Orleans Parish Medical Society,
New Orleans, La.

Gentlemen:

Upon instructions received from your treasurer, Dr. J. A. Lanford, I audited your books and accounts for the twelve months ending December 31st, 1926, and submit the following schedules covering same.

Financial Condition

The financial condition of your Association at December 31st, 1926, reflects a net worth of $66,518.27, with no liabilities ascertainable.

Gold Bonds, Library Fund	$ 6,500.00
Gold Bonds, Domicile Fund	30,000.00
Cash, General Fund	1,214.56
Cash, Library Fund	928.09
Cash, Petty in office	10.12
Medical Relief Fund	110.47
Inventory, General Fund	564.63
Inventory, Library Fund	27,190.40
	$66,518.27

The records were neatly and exceptionally well kept and all cash receipts were fully verified and all entries correctly posted. The duties having been increased in February, 1926, necessitated additional postings which a detailed check proved that all entries were properly posted.

A verification of the cash and securities were checked at the bank and found in accord with the records in the office.

Respectfully submitted,
L. L. JARREAU, Auditor.

ASSETS

Domicile Fund				
Second Liberty Bonds 4¼%				$30,000.00
General Fund				
Cash in bank, Whitney Central Natl. Bank			$1,214.56	
Petty Cash in office			10.12	
Medical Relief Fund			110.47	1,335.15
Inventory of Fixtures—Gen. Acct.				
Inventory at Dec. 31st, '25		$572.13		
Less one clock discarded		7.50		
		564.63		
acquired in 1926		None		564.63
Library Fund				
Cash in bank, Marine Bank & Trust Co.				928.09
Gold Bonds				
Sinclair Cons. Oil Corp., No. M12759		1,000.00	7%	
St. Charles Ave. Baptist Church, $500.00 each, No. D-3 & 4		1,000.00	6%	
Executive Committee of the Baptist Convention of Georgia, $500.00 each, No. 467-468		1,000.00	6%	
Missouri Pacific R. R., No. D-2043		500.00	6%	
2,500 Guilders Holland-American Line, No. 006071-006075		1,000.00	6%	
Gillican-Chipley Co. No. M1949		1,000.00	6%	
Gillican-Chipley Co. No. M2424		1,000.00	6%	6,500.00
Inventory, Library Fund, Fixtures				
Inventory on hand, Dec. 31st, '25		1,826.05		
Less reduced value of typewriter		25.00		
		1,801.05		
Acquired in 1926				
Kardex File	43.20			
One Chair	12.00	55.20		1,856.25
Inventory of Books				
Inventory on hand, Dec. 31st		24,120.91		
Acquired in 1926	241.24			
Donated in 1926—				
*238 Books @ 2.00	476.00			
*124 Books @ 4.00	496.00	1,213.24		25,334.15
				$66,518.27

*Estimated by Miss Marshall

RECEIPTS, "GENERAL FUND"

Louisiana State Medical Society	$ 240.00
Louisiana State Medical Society, Tel & Tel.	39.79
New Orleans Medical & Surgical Journal, Tel. & Tel.	14.20
Copies of reminiscences sold	3.00
Membership dues	9,009.50
	$9,306.49

RECEIPTS, "LIBRARY FUND"

Interest received on investments

Missouri-Pacific Railroad	$ 29.40
Sinclair Cons. Oil Corp.	68.60
Union Bag & Paper Co.	29.40
St. Charles Avenue Baptist Church	58.80
Holland-American Line	59.52
Executive Committee of the Baptist Convention of the State of Georgia	58.80
4¼% Second Liberty Loan Bonds	1,275.00
Proceed of sale the Union Bag & Paper Co. bond	1,050.00
	$2,629.52

EXPENDITURES, "GENERAL FUND"

Salaries

Miss Marshall, Librarian	$1,800.00	
Miss Maier, Asst. Secy.	1,200.00	
James Gardner, Porter	600.00	
Alfred Hosmer, Porter	60.00	
Charles Craig	60.00	
Miss Gertrude Pic, Stenogr.	55.00	
Miss Lothrop, Stenogr.	55.00	
L. L. Jarreau, Auditor	35.00	$3,822.00
Petty Cash	215.00	
Stationery	237.89	
Telephone & Telegraph	205.45	
Insurance	17.50	
Light, Electric, & Heat	74.92	
Ice	47.15	
Meeting Notices	7.25	
Electrical work	6.00	
New Orleans Medical & Surgical Journal	300.00	
Floral Offerings, Deceased Members	27.00	
Repairs to typewriter	22.85	
Rental of Bank Box	5.00	
Window Pane replaced	1.80	
Carpenter Repairs	9.50	
Light for office	7.80	
Rental of Picture Machine	10.00	
Prints	3.29	
Charts (Emile Jastrom)	14.00	
Stove Repairs (Baldwin)	21.75	
Election Tellers	15.00	
Banquet Expense	9.00	
Dues Refunded	32.00	
Plumbing repairs	20.00	
Keys for safe	5.50	
Miscellaneous	31.10	
Oration (Dr. A. O. Whipple)	250.00	
Whitney Bank (Bond bought)	986.33	
La. State Medical Society (Dues)	1,806.00	
Hospital Abuse "Expense"		
To Dr. Fossier	350.00	
Stenographer	15.00	365.00
		4,754.08
		$8,576.08

EXPENDITURES, "LIBRARY FUND"

Abstract & Research

Medical Library Assn.	$10.00	
W. F. Prior & Co.	15.00	
Thomas Nelson & Sons	20.00	
Oxford University Press	3.93	48.93

Magazine Subscriptions

Moore-Cottrell	444.85	
H. W. Wilson & Co.	11.00	455.85

Books

Williams & Wilkins	9.00	
J. A. Majors & Co.	62.20	
Canadian Book Co.	3.74	
Radiological Society	.60	
Interpreter Publishing Co.	62.25	
Williams Woods	6.00	
Modern Hospital	11.00	
Loranz & Co.	86.45	241.24

Binding

National Library Binding Co.	100.75	
New Method Book Bindery	274.99	
Freight & Drayage	20.17	395.91

Supplies

Democrat Printing Co.	13.06	
Andree Printing Co.	2.00	
Barber Entomological Lab.	4.85	19.91

Interest

Marine Bank & Trust Co.	33.53

Fixtures

Kardex File	43.20	
Ebert & Hall, One Chair	15.50	58.70
Petty Cash		40.00
Gillican-Chipley Co., Bonds Purchased		989.50
Marine Bank & Trust Co., Debit memo. for carrying less than $100.00 daily average in April, 1927		.50
		$2,284.07

INVENTORY OF FIXTURES

General Fund

1 Steel Filing Cabinet	$35.00	
6 Cardboard Cases	3.00	
1 Safe	30.00	
4 Wooden Tables	7.00	
2 Flat Desks	25.00	
1 Addressograph	40.00	
1 Addressograph File	10.00	
1 Underwood Typewriter	83.03	
2 Swivel Chairs	10.00	
12 Chairs	12.00	
1 Directors Table	25.00	
1 Gavel & Block	10.00	
1 Stove	38.40	
3 Rubber Rugs	3.00	
1 Stove Plate	.50	
1 Protectograph	20.00	
1 Clock	7.50	
1 Blackboard	.75	
2 Fire Extinguishers	12.00	
1 Brass Cuspidor	1.50	
5 Waste Baskets	2.50	
1 Ballot Box	1.50	
1 Multigraph	50.00	
1 Stand, "Type"	4.00	
1 Step Ladder	1.50	
1 Awning	12.65	
1 Hat Rack	1.50	
1 Globe Fixture & Light	13.95	
1 Table Lamp	11.50	
1 Translux Screen, 50 x 60	90.85	
1 Door Check	1.00	$564.63

INVENTORY OF FIXTURES & BOOKS

Library Fund

Books

Inventory at Dec. 31, 1925	$24,120.91	
Purchased in 1926	241.24	
*Donated, 238 Books at $2.00	476.00	
*Donated, 124 Books at $4.00	496.00	1,213.24
Total inventory of books December 31st, 1927		$25,334.15

Estimated by Miss Marshall
(Assistant Librarian)

Fixtures

3 Wooden Reading Tables	$9.00	
9 Chairs	9.00	
1 Oil Stove	4.00	
24 Rows Wood Shelves	150.00	
1 Ink Well	.50	
15 Rows Steel filing shelves	1,196.28	
1 Catalogue Case & Stand	125.00	
1 Book Truck	50.00	
1 Flat Top Desk	30.00	
1 Typewriter	25.00	
1 Steel Filing Cabinet	35.00	
Cardboard Boxes	100.00	
Filing Boxes	45.35	
Lights	18.42	
	$1,797.55	

Acquired in 1926

Kardex Filing Cabinet	43.20		
One Swivel Chair	15.50	58.70	1,856.25
Total Inventory Books & Fixtures			$27,190.40

CASH

General Fund

Cash on hand Jan. 1st, 1926	$484.15	
Receipts	9,306.49	
	9,790.64	
Less disbursements	8,576.08	1,214.56

Library Fund

Cash on hand Jan. 1st, 1926	582.64	
Receipts	2,629.52	
	3,212.16	
Less disbursements	2,284.07	
Cash on hand Dec. 31st, 1926		$2,142.65

DOCTORS ELECTED TO ACTIVE MEMBERSHIP IN 1926

1. Castellani, Aldo	10. Lisenby, J. O.
2. deReyna, George	11. Ernst, H. O.
3. Souchon, Edward	12. Jones, P. H., Jr.
4. Peterman, E. S.	13. Mendelson, R. W.
5. Calhoun, W. W.	14. Sicomo, J. F.
6. Williams, C. T.	15. Warren, D. D.
7. Wirth, W. R.	16. Rich, F. G.
8. Turner, R. H.	17. Magruder, L. W.
9. Powe, A. McK.	18. Montelepre, P. W.

INTERNE MEMBERSHIP

Elected in 1926

1. Feldner, G. D.	11. Donald, J. M.
2. Lombard, J. H.	12. Ganier, W. V.
3. Rosen, W. L.	13. Hunter, M. W.
4. Smith, John F.	14. Winter, H. H.
5. Zweigel, Isidore	15. Schaefer, Suzanne
6. Owen, B. G.	16. Culley, P. G.
7. Clayton, J. E.	17. Weinberger, H. L.
8. Shepard, S. C.	18. Willoughby, R. M.
9. Goldsmith, Ben	19. Peavy C. D.
10. Duffy, M. J.	

RESIGNATIONS.

1. Clayton, J. E.
2. Flowers, W. W.
3. Goldsmith, Ben
4. Hill, Chas. W.
5. Johnson, J. A.
6. Kibbe, Chas. W.
7. Lockard, J. N.
8. Lucas, J. F.
9. Rodicks, J. C.
10. Shepard, S. C.
11. Smith, John F.
12. Stookey, L. J.
13. White, H. A.
14. Winters, H. H.
15. Zweigel, Isidore

MEMBERS REINSTATED.

Hume, J. R. Hava, F. C.
Battalora, G. C.

MEMBERS DECEASED.

1. Jones, H. P.
2. McGuire, M. H.
3. Nelken, A.
4. Oechsner, John F.
5. Pothier, O. L.
6. Weaver, W. H.

INSURANCE.

Liability

Employers Liability Insurance Co., Policy No. 359526, maturing February 15th, 1928, issued through Sam George Insurance Agency.

Surety Bond

United States Fidelity & Guarantee Co.,
Dr. John A. Lanford, Policy No. 8752-21, expiring Feb. 24/28 ..... $1,000.00
Miss L. Maier, Policy No. 20019-23, expiring Oct. 19/27 ..... 2,000.00

Fire

Hudson Insurance Co., thru Sam George Insurance Agency.
Policy No. 373463, Expiring Feb. 1st, 1930 ..... $11,000.00
Policy No. 373462, Expiring Jan. 12th, 1930 ..... 3,000.00
Policy No. 373465, Expiring Jan. 19th, 1930 ..... 3,000.00

Columbia National Fire Insurance Co., thru J. A. Corales Insurance Agency, Policy No. 711154, Expiring Sept. 12th, 1929 ..... 9,000.00

Total Fire Insurance on books and Fixtures $26,000.00

LOUISIANA STATE MEDICAL SOCIETY NEWS

H. Theodore Simon, M. D., Associate Editor.

REPORT OF HOUSE OF DELEGATES TO GENERAL ASSEMBLY.

Gentlemen:

I wish to report the following activities of the House of Delegates, representing the business attended to during their several Sessions of the Annual Meeting.

Various reports from the Executive Officers and Standing Committees were presented and taken up under the proper order of business. As a result of these reports, it was voted to establish throughout the State special Legislative Committees in every Parish to function with our State Legislative Committee on future matters of interest.

Owing to the unusual water conditions which more or less appear at the same time in which our meeting has been held, it was recommended to the Executive Committee that in the future the meeting should be held at a time when this contention would not arise to prevent the proper functioning of our Society.

DR. HUBERT A. ROYSTER
RALEIGH, N. C.
ANNUAL ORATOR, LOUISIANA STATE MEDICAL SOCIETY

The experiment tried this year by the Committee on Scientific Essays, that of dividing the Scientific Meeting into two sections, Medicine and Allied Branches, and Surgery and Allied Branches, running simultaneously, has met with such favor and approval that the House of Delegates adopted the plan and asked that it be continued in the future. In order to intensify the Scientific Program, the Chairmen of various Sections will be appointed thirty days after the President takes office, and thus will be able to

The Committee on Public Policy and Legislation gave a very inclusive report, and as a result it was voted that a special fund of $500.00 per year should be appropriated for the use of this Committee.

The report of the Journal showed that the fiscal affairs were in excellent shape, and that intensive plans were made for maintaining and increasing its scientific usefulness.

Upon recommendation of the Councilor from the Fourth District, Dr. S. C. Barrow, it was recommended that in the future the Annual Meetings be held more frequently in the country, leaving it to the discretion of the House of Delegates to determine said meeting place.

At the request of the Committee on Medical Defense, it was deemed advisable that more suitable propaganda should be disseminated looking toward taking the public into our confidence, which would be in a way reflected in the lessening of mal-practice suits.

Upon motion, the Journal Committee was requested to bring in a report covering their position in regard to refusing the advertisement of the New Fenwick Sanitarium. After considerable discussion on this subject, it was decided that the investigation of the New Fenwick Sanitarium should be made by our Committee on Hospitals, they in turn to report to the Journal Committee within sixty days from the date of meeting.

The name of Dr. Roy B. Harrison to succeed himself as a member of the State Board of Med-

ical Examiners, and also the name of Dr. Lucien A. Fortier, were passed and requested to be sent to the Governor for consideration.

It is interesting to note that provisions were made for the including of the specialties of Orthopedics and Gastro-Enterology in the future programs of the Society.

Resolutions were presented and passed expressing appreciation to Dr. Blackshear, our President, and Dr. Talbot, Secretary-Treasurer, for the valuable services rendered during the past years.

The Committee on Resolutions presented an appropriate report thanking the various agencies, individuals and institutions for their work and assistance in lending every possible means toward making our present meeting a success.

Owing to a request by a Conference of National and State Medical organizations at Memphis, being held on Thursday, April 28th, the House of Delegates delegated Dr. Blackshear to attend the meeting. Appropriate resolutions were offered and adopted calling our attention to the present urgent flood conditions, and offering the services of organized medicine to any contingencies that might arise.

Resolutions were offered as a matter of record calling our attention to the fact that one of our past Presidents, Dr. Rudolph Matas, had been so signally honored recently in London at the Lister Centenary by the Royal College of Surgeons.

Baton Rouge, Louisiana, was selected for the next Annual Meeting.

Dr. J. J. Ayo of Raceland was unanimously elected as Speaker of the House. Dr. Paul J. Gelpi was elected to fill the vacancy on the Journal Committee created by Dr. Herold having become President of our organization. Dr. Hermann B. Gessner was elected to the term of three years on the Journal Committee.

The following officers and Committees after being duly nominated were elected to office:

President—Dr. A. A. Herold, Shreveport.

President-Elect—Dr. L. J. Menville, New Orleans.

1st Vice-President—Dr. D. I. Hirsch, Monroe.

2nd Vice-President—Dr. C. C. DeGravelles, Morgan City.

3rd Vice-President—Dr. J. Birney Guthrie, New Orleans.

COUNCILORS:

Third District—Dr. F. T. Gouaux, Lockport.

Sixth District—Dr. C. A. Weiss, Baton Rouge.

Seventh District—Dr. D. C. Iles, Lake Charles.

Eighth District—Dr. G. M. G. Stafford, Alexandria.

Delegate to American Medical Association—Dr. S. M. Blackshear.

Alternate to American Medical Association—Dr. D. I. Hirsch.

COMMITTEES:

Committee on Scientific Work—Dr. P. T. Talbot, Chairman; Dr. A. E. Fossier, Dr. Elizabeth Bass, all of New Orleans.

Committee on Public Policy and Legislation—Dr. B. A. Ledbetter, Chairman, New Orleans; Dr. E. L. Leckert, Dr. Roy B. Harrison, President and Secretary; all of New Orleans.

Committee on Publication—Dr. P. T. Talbot, Chairman; Dr. Chas. Chassaignac, Dr. Jules Dupuy, all of New Orleans.

Committee on Medical Education—Dr. S. C. Barrow, Chairman, one year, Shreveport; Dr. John A. Lanford, two years, New Orleans; Dr. Maurice J. Gelpi, three years, New Orleans.

Committee on Medical Defense—Dr. P. T. Talbot, one year, New Orleans; Dr. E. L. Sanderson, two years, Shreveport; Dr. R. O. Simmons, three years, Alexandria.

Committee on Hospitals—Dr. Chas. Chassaignac, Chairman, New Orleans; Dr. J. L. Scales, Shreveport; Dr. O. P. Daly, Lafayette; Dr. C. P. Gray, Monroe; Dr. A. J. Comeaux, Youngsville.

Committee on Health and Public Instruction—Dr. W. H. Seemann, Chairman, New Orleans; Dr. F. R. Gomila, New Orleans; Dr. G. M. Stafford, Alexandria; Dr J. Q. Graves, Monroe; Dr. J. K. Griffith, Slidell.

Respectfully submitted,

P. T. TALBOT,
Secretary-Treasurer.

REPORT OF COMMITTEE ON MEDICAL EDUCATION.

To the President and House of Delegates, Louisiana State Medical Society, 1927.

Gentlemen:

As will be observed, your Committee this year has been principally concerned with the medical

curriculum, and begs therefore to make the following report:

Starting with the fundamental idea that medical education should have as its primary object the proper and efficient treatment of sick human beings, certain modifications in the curriculum strongly suggest themselves.

1. The present curriculum offers inadequate contact between the student and the patient. This applies particularly to the first three years of medical teaching, including the premedical year. During these three years, amounting to three-fifths of the entire educational period, the contact is practically nil. This idea has recently been stressed by Hugh Cabot before the Association of American Medical Colleges.

2. There are at present too many lectures in the curriculum. In this connection, your Committee feels as has been said, that "no one can teach the art or the science of the practice of medicine by the lecture system." Much of the time now spent by the student in the lecture room, might be spent to considerably more advantage either in the out-door clinic or in the wards.

3. While your Committee does not belittle the importance of laboratory teaching, for the making of good, practical doctors, a disproportionate period of the student's time is spent in the laboratory. As stated by Ray Lyman Wilbur of Stanford University, "It is interesting from a historical standpoint to note that when the laboratories came along, they were captured in an educational sense by clinical medicine, but they now have captured their captor."

4. The fact is often deplored by medical educators, that so many students want to be surgeons. Is not this an evidence perhaps that too much stress has been laid upon and too much time given up to major surgery?

Your Committee feels therefore that the product of the medical school would be a better equipped practitioner, if this excess of laboratory and lecture time were given over to the study, examination and treatment of patients, and if this excess of major surgical teaching were devoted to the same end.

Your Committee deplores the apparent increasing control of medical education by endowments—those permanently established, enormous sums which must be utilized for specific purposes exclusively. By thus fixing and determining the educational conduct of universities or medical schools, not only in a general but even in a detailed and specific manner, there is a tendency to overstandardization and stifling of individuality and personality in teaching. Your Committee is in accord therefore with the note of warning recently sounded by Professor Zinsser of Harvard Medical School. This warning is timely and worthy of serious consideration, particularly on the part of those seeking assistance from philanthropic sources.

Finally, it is suggested that the teaching of the "Principles of Medical Ethics" be included in the curriculum as recommended by the Council on Medical Education of the American Medical Association.

The Committee realizes that at best but little can be accomplished by these yearly reports, except perhaps to put the Society on record as being interested. However, something practical may be accomplished eventually by persistently sending these reports to the educational bodies actually controlling the medical curricula.

Be it therefore resolved, That a copy of this and subsequent reports be sent to the following organizations:

The Association of American Medical Colleges; the Deans of the Component Members; the Council on Education of the American Medical Association; the Rockefeller Foundation; and the Carnegie Foundation.

Respectfully submitted,

MAURICE J. GELPI, Chairman,
Committee on Medical Education.

JOHN A. LANFORD, Member.
S. C. BARROW, Member.

DR. RUDOLPH MATAS HONORED AT LISTER CENTENNIAL.

Dr. Rudolph Matas, retiring Professor of Surgery in Tulane University School of Medicine, was made an Honorary Fellow of the Royal College of Surgeons in England on the occasion of the celebration of the Lister Centennial on April 5, 1927. This is a very high honor as honorary fellowships are conferred by the Royal College of Surgeons only on rare occasions, and then only on surgeons of great distinction.

The results of the Louisiana State Medical Society Golf Tournament were as follows:

Dr. F. Temple Brown as medalist won the I. L. Lyons cup.

Dr. Val H. Fuchs runner up won the Louisiana State Medical Society cup.

Dr. N. K. Edrington, Destrahan, with low net score of 67 won the Hausmann Inc. cup.

Dr. Allan Eustis, Sugical Supply Trophy.

Dr. J. B. Duval, Houma, the McDermott Surgical Instrument Company.

Dr. Paul A. LeBourgeois and family of Jeanerette are now comfortably located in their home on East Main street. Dr. LeBourgeois has also rented a suite of offices on the second floor of the Cage building where he will practice his profession as specialist in the treatment of the eye, nose and throat. We welcome him and his little family to this community. In this instance, Jeanerette's loss is New Iberia's gain.

MERCY HOSPITAL STAFF MEETING.

At the regularly monthly meeting of the Staff of the Leonce-Mercy Hospital held May 20, 1927, the following cases were presented by Dr. Maurice Campagna:

1. A case of acute encephalitis occurring in a nineteen-year-old white boy. Up to the sudden acute onset the patient was apparently well. No prodromate could be elicited from the history and the disease progressively advanced to a fatal termination within a period of four days. The antimortem signs were classical for brain tumor but the post-mortem findings were of extreme interest due to the great amount of infiltration and congestion of the blood vessels of the cerebrum bringing about an extensive softening in such a surprisingly short time.

2. A rare case of malignancy of the pericardium occurring in a white male age 46 years. Epidermoid in type and metastasizing from an epidermoid tumor of the left side of the scalp. The lungs were envolved to a small extent around the hilus. No envolvement of the endocardium or myocardium. The pericardial cavity was completely obliterated and the pericardium presented a marked thickening.

Drs. Jamison and Campagna presented a yearly report on the medical clinic of the institution emphasizing the large number of tubercular patients and the environmental draw backs precluding a successful combating of this malady. A total of 1171 patients were treated in the medical department with twenty-four admissions through the clinic. Of these four died, sixteen were discharged as well or improved and four were reported as unimproved. Three autopsies were obtained.

After the June meeting the staff will not meet again until September, 1927.

Two Senior Medical students were selected from a number of applications to serve as clinical clerks for the coming year.

SABINE PARISH MEDICAL SOCIETY.

There was a meeting of Sabine Parish Medical Society at the Court House in Many, Tuesday, May 10th, at 2 o'clock P. M.

Vernon Parish Medical Society was invited to meet with Sabine Parish Medical Society at this time.

There was no scientific program arranged ahead of time, but each physician present was given a chance to present a short paper, or case report for discussion.

DR. F. W. PARHAM, FAMOUS SURGEON, CALLED BY DEATH.

Dr. Frederick William Parham, noted New Orleans surgeon, who had been honored by many universities and associations of doctors for his accomplishments in surgery which brought him international fame, died May 6, 1927, at his residence, 1429 Seventh street, following an illness of several months.

Funeral services were held from the residence Saturday afternoon, May 7, at 3 o'clock, with Bishop Davis Sessums officiating.

Dr. Parham was born in New Orleans, March 20, 1856, the son of John Greenway Parham and Mary E. Blunt. On December 15, 1892, he married Miss Mary K. Duncan of New Orleans, who survives him. To this union six children were born, four of whom survive. They are Fred D. Parham, well-known New Orleans architect; Dr. Duncan Parham, Titusville, Pa., and Mrs. Mildred Parham and Miss Mary Parham, New Orleans.

He is also survived by a brother, B. B. Parham of Natchez, Miss., and a sister, Mrs. Philip Werlein, formerly Miss Betty Parham.

GAINED FAME.

Dr. Parham had an international reputation as a surgeon, due to many new and daring operations he performed while assistant resident surgeon at Charity Hospital and professor of surgery at the New Orleans Polyclinic, now the graduate school of Tulane University. He also perfected several devices that have come into common use in the practice of surgery.

Some of the outstanding surgical achievements of Dr. Parham were in the field of intestinal surgery. He performed many brilliant operations in

this field and was the author of many papers devoted to this particular branch of surgery.

The first thoracic operation performed in this country of which there is a record was performed by Dr. Parham here in 1898. It was for the removal of a tumor on the bony wall of the chest.

SURGICAL INVENTOR.

Dr. Parham, working with Dr. E. Denegre Martin, perfected what is known as the Parham-Martin band for use in oblique bone fractures. According to Dr. Lund, a well-known Boston surgeon, it formed one of the most important contributions to surgical instrumentation.

Dr. Parham also wrote much of surgical shock. His work to lessen the danger from this source formed one of his outstanding efforts and served to attract attention to him from the men of his profession throughout the world.

One of the last papers published by Dr. Parham was read before the Louisiana State Medical Association in 1926. The subject discussed was head injuries that made for intra-cranial tension.

MANY HONORS.

Dr. Parham was honored with office and membership in many medical and surgical organizations and in 1925 was given the degree of doctor of laws by Tulane University. He was one of six medical men graduated from Tulane so honored by his alma mater.

In the same year 150 fellow surgeons and physician celebrated Dr. Parham's sixty-ninth birthday anniversary in a reception at Charity Hospital, with which he had been connected for forty years, and presented the institution with an oil portrait of Dr. Parham.

At that time Dr. Parham was given credit for having been most active in developing an efficient co-operation between the administrative board of Charity Hospital and the staff of visiting surgeons. Also, he was said to have done much toward the development of antiseptic and aseptic surgery to its present importance and efficiency. For this and the part he had played in a material lowering of the New Orleans death rate it was said that Dr. Parham had won international recognition.

HELD MANY OFFICES.

Dr. Parham was a fellow of the International Society of Surgeons. He was vice-president of the American Surgical Association in 1917 and was a member of the board of regents of the American College of Surgeons from 1920 to 1926.

In 1908 Dr. Parham was elected president of the Southern Surgical and Gynecological Association and was president of the Louisiana State Medical Association in 1902. In 1895 he was president of the Orleans Parish Medical Society.

Dr. Parham also was a member of the American Medical Association and of the Phi Delta Theta.

In 1877 he was admitted by competitive examination to the Charity Hospital, where he served as interne with distinction for two years, notably during the malignant epidemic of yellow fever in 1878. From that time his interest in the Charity Hospital never faltered. This active interest throughout a period of fifty years was invaluable to the institution.

Dr. Parham was assistant house surgeon of the Charity Hospital from 1885 to 1887. One of his brilliant accomplishments was the inauguration and execution of a system of antiseptic and aseptic methods which practically eliminated the fearful mortality caused by puerperal fever in the maternity wards.

DEATH CLAIMS DR. McCUTCHON, NOTED PHYSICIAN.

Dr. Percival Butler McCutchon, for more than a generation one of the leading physicians of New Orleans, died in Touro Infirmary, after a prolonged illness.

Funeral services were held at 9:30 a. m. Friday, May 13th, from his residence, 4020 Prytania street. The body was sent to Pass Christian, Miss., for burial.

Dr. McCutchon was born in Pass Christian, February 7, 1852. He graduated from Virginia Military Institute in 1873 and was assistant professor of Latin and tactics there until 1876. Coming to New Orleans, he became a resident student at Charity Hospital in the first class admitted by competitive examination in 1877. Graduating in medicine and pharmacy at Tulane University in 1879, Dr. McCutchon was appointed assistant demonstrator in anatomy and served as such until 1881.

From 1879 to 1883, Dr. McCutchon was sanitary inspector for the national board of health and held the same position with the Louisiana state board of health in 1884 and 1885. He was secretary of the Orleans Parish Medical Society for several years and served as president of that body in 1884. He was secretary of the Louisiana State Medical Society from 1883 to 1899. He was made an honorary member of the Orleans Parish Medical Society on April 12, 1926.

Dr. McCutchon was second vice-president of the Louisiana State Board of Health from 1899 to

1907, and served as physician of the Protestant-Episcopal Children's Home for forty years, and the Waldo Burton Memorial Home for thirty years.

Besides his wife, formerly Miss Annie Salkeld Davis, Dr. McCutchon is survived by one daughter, Miss Rebecca Butler McCutchon, two sons, Percival Butler, Jr., and E. Davis McCutchon, and one brother, F. B. McCutchon of Pass Christian.

DIED: Dr. Joseph Edgar Johnson, Gandy, Louisiana; Medical Department of Tulane University of Louisiana, New Orleans, 1912; member of the State Medical Association of Texas; aged 49; died November 11, 1926, at Houston, Texas, of acute appendicitis.

Dr. M. T. Van Studdiford is leaving for three months in Europe to attend skin clinics in the large medical centers.

SUMMER CLINICS IN CHICAGO.

Announcements and schedules will soon be ready for the 1927 Summer Clinics of the Chicago Medical Society, supported by many of the largest hospitals in the city, among them being the Post Graduate Hospital, Chicago Memorial Hospital, University of Illinois College of Medicine, Cook County Hospital, Michael Reese Hospital, Mercy Hospital, Presbyterian Hospital, Jackson Park Hospital, St. Luke's Hospital, Ravenswood Hospital, Mount Sinai Hospital, Francis Willard Hospital, West Suburban Hospital, Evangelical Hospital, North Chicago Hospital, Chicago Lying-in Hospital, St. Joseph Hospital, Alexian Brothers Hospital, Laboratory of Surgical Technique, Washington Park Hospital, Jackson Park Hospital, Chicago Municipal Tuberculosis Sanitarium, John B. Murphy Hospital. Several of our large laboratories have also agreed to co-operate with us in this great work.

In 1926 they limited registrations to physicians living in Illinois, but the increased facilities make it possible to accommodate many more than last year. Registrations therefore will be open to physicians from other states and to as many as may be accommodated, in the order of their registration. Registration fee will be $10 for each two weeks course, payable at time of registration, and a physician may register for only one course of two weeks.

Admission will be by card only, issued by the Chicago Medical Society and no registration card will be issued until registration fee is paid.

The first two weeks course will begin on Monday, June 13th, 1927, at 9 a. m., ending Friday, June 24th.

The second two weeks course will begin on Monday, June 27th, at 9 a. m., ending Friday, July 8th.

This is an excellent opportunity for the medical men of the country to obtain real post-graduate work in some of the best hospitals in the world, and from some of the best clinicians found anywhere.

Schedules will be sent to the 10,000 physicians in Illinois, and anouncements will be sent to the American Medical Association, and the several state medical journals.

They will probably be unable to accommodate all those desiring this wonderful clinical course, so it behooves those interested to register early if they desire to take advantage of this year's clinics. Last year the registrations closed one week after the first announcement.

SENIOR MEDICAL TECHNICIAN.

(*Bacteriology*)

MEDICAL TECHNICIAN

(*Bacteriology*)

SENIOR MEDICAL TECHNICIAN.

(*Roentgenology*)

MEDICAL TECHNICIAN.

(*Roentgenology*)

Applications will be rated as received until June 30, 1927.

The United States Civil Service Commission announces that hospitals of the United States Veterans' Bureau and the United States Public Health Service throughout the country are *urgently* in need of technicians as described above and that applications for the positions will be received until the close of business on June 30, 1927. Applications will be rated currently as they are received and certification of eligibles will be made as the needs of the service require.

JUNIOR MEDICAL OFFICER.

(*Interne*)

Applications for junior medical officer (interne) must be on file with the Civil Service Commission at Washington, D. C., not later than June 30.

The examination is to fill vacancies in Veterans' Bureau Hospitals throughout the United States, and in positions requiring similar qualifications.

The entrance salary in the field service of the Veterans' Bureau is $1,860 to $2,400 a year, without allowances, or $1,260 to $1,860 a year with quarters, subsistence, and laundry, the entrance salary within the range stated depending upon the qualifications of the appointee as shown in the examination and the duty to which assigned.

The duties, under immediate supervision, are to admit patients, take histories, make physical and mental examinations and record findings; to make ward rounds of inspection, note charts, record observations; to prescribe for minor ailments or for acute emergency cases and to dispense medicine in emergency; to perform minor surgical operations and to assist at major operations and in redressing; to administer anaesthetics; to make routine laboratory tests and analyses; to assist at outpatient clinics in dressing and in administering vaccines; to keep records, make up case histories, answer correspondence relating to patients, and compile statistics requiring medical training.

Competitors will not be required to report for examination at any place, but will be rated on their education, training, and experience.

Full information may be obtained from the United States Civil Service Commission, Washington, D. C., or the secretary of the board of U. S. civil service examiners at the post office or customhouse in any city.

ASSISTANT MEDICAL OFFICER.
ASSOCIATE MEDICAL OFFICER.
MEDICAL OFFICER.
SENIOR MEDICAL OFFICER.

Applications will be rated as received by the United States Civil Service Commission at Washington, D. C., until June 30.

Appointments from these examinations will be made to the Veterans' Bureau, the Indian Service, the Public Health Service, the Coast and Geodetic Survey, the Panama Canal Service, the Departmental Service at Washington, and other branches.

The demand for specialized medical officers in the Federal service is constant and the supply of eligibles is rarely equal to the demand. There is opportunity for appointment of specialists in practically all branches of the profession.

Applicants will not be required to report for written scholastic tests, but will be rated on their education and training, and their practical experience.

Full information may be obtained from the United States Civil Service Commission, Washington, D. C., or the secretary of the board of U. S. civil service examiners at the post office or customhouse in any city.

LOUISIANA DOCTORS WHO ATTENDED A. M. A.

Alexander, Lucian W., New Orleans; Bamber, James M., New Orleans; Bass, Elizabeth, New Orleans; Blackshear, S. M., New Orleans; Brent, Waller H., Hammond; Buffington, W. R., New Orleans; Butler, H. W., New Orleans; Cazenavette, L. L., New Orleans; Cohn, Isidore, New Orleans; Corbin, Robert Adwood, New Orleans; Dupuy, Homer, New Orleans; Elliott, John B., New Orleans; Engelbach, Theodore, Grand Lake; Eshleman, Charles L., New Orleans; Eustis, Allan, New Orleans; Gately, Tracy T., New Orleans; Heath, Arthur G., Shreveport; Henderson, W. F., New Orleans; Johns, F. M., New Orleans; Kearney, Harold Leslie, New Orleans; Knolle, Wilkes Adams, New Orleans; Lemann, I. I., New Orleans; Levy, Louis, New Orleans; Lyons, Randolph, New Orleans; Mangham, A. D., Elizabeth; von Meysenbug, L., New Orleans; Moss, Olin W., Lake Charles; Murphy, H. A. Garyville; Musser, J. H., New Orleans; Roussel, J. N., New Orleans; Ross, John K., Algiers; Salatich, Peter B., New Orleans; Samuel, E. C., New Orleans; Tumbleson, Talbot Austin, New Orleans; Unsworth, C. V., New Orleans; Unsworth, H. R., New Orleans; Walker, Joseph D., Carson.

MISSISSIPPI DOCTORS WHO ATTENDED A. M. A.

Barrett, I. W., Lyon; Blount, E. N., Bassfield; Blount, W. N., Laurel; Buchanan, C. C., Hattiesburg; Catching, J. M., Hazlehurst; Elam, W. T., St. Joseph; Lucas, J. F., Greenville; McRae, B. J., Crandall; McWilliams, Charles A., Gulfport; Mitchell, C. D., Jackson; Rafferty, Donald G., Pass Christian; Raiwold, M. W., Pass Christian; Street, Augustus, Vicksburg; Strong, Robert A., Pass Christian; Towns, Sherrod R., Union Church; Waldrep, Newman C., Tishomingo.

MISSISSIPPI STATE MEDICAL ASSOCIATION NEWS

J. S. Ullman, M. D., Associate Editor.

A MESSAGE FROM THE PRESIDENT.

"Through the New Orleans Medical and Surgical Journal, I want to express my appreciation for the unanimous vote by acclamation that elected me and showed that all factions have been eliminated. It is yet too early to give a definite outline of policy but the general purpose of this administration will be to carry out and continue our co-operation with the State Board of Health and the medical institutions of this state which have made such a splendid showing in the past. I feel that I need the co-operation of every medical man in Mississippi if I am to accomplish anything. I assure you that I shall try to show my appreciation by doing my best."

(Signed) JOHN DARRINGTON.

As we go to press the minutes of the meeting of the Mississippi State Medical Association at Jackson have not been received but we are able to announce the election of the following officers:

President—John Darrington, Yazoo City.

Vice-Presidents—Edwin Benoist, Natchez; E. S. Bramlett, Oxford; E. L. Posey, Jackson.

Councilor Sixth District—W. G. Gill, Newton.

Councilor Seventh District—E. M. Gavin, Richton.

The meeting place for 1928 will be in Meridian.

The editor of this column felt that his duty was at home on account of the flood situation. The secretary writes that there were more than 250 registered at Jackson and that the program was unusually good.

At the request of Gov. Dennis Murphree and Dr. F. J. Underwood, Dr. R. H. Foster of Laurel, Mississippi, made an inspection tour of the flooded district the early part of last month.

Dr. Baylis of Laurel has volunteered his services for work among the refugees in the Mississippi Delta.

The refugee camps at Vicksburg and Natchez have been doing good work and the splendid health conditions in both camps are due to the work of the local physicians. It is well worthy of remark that in both camps thousands of people coming in without warning have been cared for promptly and so efficiently that there has been no epidemic.

Since early in 1900 Dr. Jones has been active in the life of Mississippi State institutions, having

Dr. May F. Jones has resigned her post at the Mississippi State Sanatorium because of ill health and returned to her home in West Point, Virginia, been identified with the Mississippi State Woman's College at Columbus, the State Teachers' College at Hattiesburg and the Mississippi State Sanatorium, having been the first Assistant Superintendent of the latter institution. For four years Dr. Jones was in charge of the field work carried on by the sanatorium.

Dr. Jones was the first woman to be admitted to the Mississippi State Medical Association as being the first woman to take the state board medical examinations. She is also the author of "Keep Well Stories for Little Folks" which is used to teach health lessons to all third grade boys and girls in both Mississippi and Georgia.

Dr. Jesse L. Roark of Water Valley, Mississippi, has come to the sanatorium to take over the duties formerly in charge of Dr. May Jones. Dr. Roark received his medical training at Jefferson Medical College at Philadelphia and also interned in the hospital of this college. Dr. Roark has been engaged in private practice at Water Valley for the last year. He and his charming wife make an attractive addition to the Sanatorium group.

Dr. Henry Boswell and Dr. B. B. O'Mara were called to Natchez during the latter part of May to assist in work in the refugee camp there. Dr. O'Mara returned to duties at Sanatorium after a couple of days. Dr. Boswell was gone for several days, working in the inundated districts.

DIED: Dr. Furtunato Bottista Sirianni, Greenville, Mississippi; University of Naples, 1898; served during the World War, aged 52, died March 1.

DIED: Dr. W. H. A. Bemis, Pope, Mississippi; Memphis Hospital Medical College, 1884; aged 75; died March 4 of paralysis.

DIED: Dr. William H. Broomfield, Mound Bayou, Mississippi; Meharry Medical College, Nashville, Tennessee, 1902; aged 43, died in April of injuries received when the automobile in which he was riding was struck by a train.

DIED: Dr. Herbert M. Haley, Utica, Mississippi (licensed Mississippi, 1882) aged 74, died suddenly April 12.

DIED: Dr. Harry Greenwell Fridge, Hattiesburg, Mississippi, Medical Department of the Tulane University of Louisiana, New Orleans, 1904; served in France during the World War, aged 47; was killed March 31, in an automobile accident.

BOOK REVIEWS

Text-Book of Urology: By Oswald S. Lowsley, A. B., M. D., F. A. C. S., and Thomas J. Kirwin, Ph. C., B. S., M. A., M. D., F. A. C. S. With 233 engravings and 13 plates. Philadelphia, Lea & Febiger. 1926.

In the past few years several new texts on urology have appeared which have added materially to our knowledge concerning this most important specialty of surgery. In no single-volume work on urology has the reviewer noted more originality than is to be found between the two covers of the book written by Lowsley and Kirwin.

Dr. Lowsley received international recognition years ago in his original investigations dealing with the embryology and histology of the prostate gland. In recent years he has been one of the most enthusiastic advocates of regional anesthesia, particularly as it applies to kidney and prostatic surgery.

Dr. Kirwin is well known to a host of our readers, having been a member of the graduating class of Tulane '17. We feel a just pride in the position he has attained in organized medicine in New York City. Holding the position of chief of clinic in the Brady Urological Foundation, New York Hospital, under Dr. Lowsley, who is director of the foundation, he has had unlimited clinical facilities for studying the surgical ailments of the urogenital apparatus.

The chapter dealing with a historical review of urological surgery represents much reading and investigation. It is the most complete piece of work on the subject that the reviewer has ever read. A chapter on history-taking and physical examination is most thorough and illuminating. Cystoscopy and roentgenological diagnosis are described in detail and an interesting feature is a description of the new Lowsley cystoscopic table as well as the new Lowsley cystoscopic rongeur.

Chapter V deals with the penis and prepuce and includes anomalies, hypospadis, injuries, diseases, ulcers, cancer, operative and non-surgical care, of these structures. In other chapters that follow, the authors take up the scrotum, testicles, epididymes, vasa deferentia and seminal vesicles. The male urethra, Cowper's glands, the female urethra—all are accorded separate chapters in which the disease and surgery of these organs are dealt with in modern fashion.

Chapter XI which deals with the prostate is probably the most interesting chapter in the book. The investigations of Lowsley on the embryology and histology of the prostate, already referred to above, are given here and are most interesting reading. It was mainly through the studies of Lowsley that we teach today that the prostate is divided into five lobes, namely, the middle, the two lateral, the posterior, and the anterior or ventral. Both the suprapubic as well as the perineal approach in prostatectomy are fully described and illustrated. The authors prefer the perineal route and state their reasons for having adopted same. Parasacral block with 30 c.c. of a 1 per cent procain solution is their choice mode of anesthesia in prostatectomy. Their technique in perineal enucleation of the prostate is a modification of Young's. Their ingenious method of keeping patients dry following bladder operations by means of a water suction-pump will unquestionably commend itself to many.

Chapters on the bladder, the ureters and the kidneys give all data referable to the modern management of the disease to be found in these organs. The surgical care of bladder tumors, ureteral stones, renal stones, infections and new growths of the kidneys, are all covered in a way that makes their reading interesting as well as instructive.

The illustrations in the books are excellent throughout, the print is sufficiently large to read with ease and the various subheads in bold print make it easy for the reader to find readily the point in which he is chiefly interested. For those about to take up urology as a specialty the book is especially recommended. The general physician as well as the general surgon will find in it a valued compendium. Within its covers will be found everything a medical student should be informed on as regards the field of urology.

H. W. E. WALTHER, M. D.

Symptom Diagnosis — Regional and General: Wilfred M. Barton, A. M., M. D., F. A. C. P., and Wallace Yater, A. B., M. D. New York, D. Appleton & Co. 1927.

This book is an excellent "trouble locator." In these days of rapid living where the demand for a quick and accurate diagnosis is expected, the busy practitioner will find here a dependable help.

The arrangement of the matter is convenient and the type clear with the principal headings in bold character. The first part is devoted to regional symptoms. This forms the greater part of the work. The last third of the book deals with general symptoms.

The book is all the authors claim for it—a handy book to have on the desk which you can open at the chapter describing all the possible ills which a patient can have in the ailing area.

A quick glance at the bold type helps the memory to the right page.

The reviewer is not an advocate for quick and easy ways in medicines because such tend to limit the energy especially of young men and prevent them from using their own powers of observation and deduction to the best advantage. For these he considers this book a very valuable method of checking the correctness of their deductions *after* all the study of the case is completed. Older men will find in it a good help to memory.

NARCISSE THIBERGE, M. D.

The Life and Times of Adolf Kussmaul: By Theodore H. Bast, Ph. D. New York, Paul B. Hoeber. 1926.

A significant feature of the recent renaissance in the study of medical history is the interest displayed in those figures of eponymous fame. Sir William Osler was accustomed to use eponyms in his unique methods of instructions. Dr. Joseph Pratt has left us a charming account of his investigating (at his teacher's request) the concocter of Pilulae Ferri Carbonatis. Sir D'Arcy Power is currently favoring us with an enlightening series of eponyms in the British Journal of Surgery, which will richly reward the reader. Now Professor Bast familiarizes the medical profession with a pathfinding physician of the turbulent nineteenth century—whose name every student associates with that type of respiration so characteristic of diabetic coma—Kussmaul air hunger.

Unfortunately Kussmaul's "Reminiscences of an Old Doctor" is not available in an English translation. Perhaps it may be fortunate, for its charm and wisdom could only be mutilated in an alien tongue. Its merit is testified by the numerous editions—fourteen—through which it has run in Germany. One might consider Dr. Bast's volume an abstract of the "Errinerungen." The first part of the book is given over to Kussmaul's adolescence, and while entertaining, in a large measure, is entirely too saccharine a presentation. Kussmaul's later experiences call up a comparison with the late dean of British clinical investigation, Sir James Mackenzie. Both underwent the rigors of country practice, rising through this medium to the loftiest possible heights.

What do we owe to Kussmaul's ceaseless industry, his uncanny acumen? He was the strongest link in the chain of workers who laid the foundation stones for Helmholtz' genius to give us the ophthalmoscope. The obstetrician remembers him for his classic studies on transmigration of the ovum. Pediatrist and neurologist acclaim his masterpiece on speech disturbances. While he was not the first to use the stomach tube (as is generally held) credit is due him for having given the impetus for its general application. We might mention other contributions, such as the description of periarteritis nodosa, the use of drainage in empyema—all examples of his extraordinary versatility.

Undoubtedly the reader will profit from a sitting with Dr. Bast's volume. In the absence of a translation of the master's autobiography, an outstanding treasure of medical biography, it suffices to give us a good account of his life and times.

M. MALLOWITZ.

Human Pathology: By Howard T. Karsner, with an introduction by Simon Flexner. Philadelphia, J. B. Lippincott Co. 1926.

This text of pathology presents the modern views of the subject. Unfortunately, the consideration of certain important diseases, notably the exanthemata have been omitted and still others are but incompletely described. There is considerable but incomplete literature cited, especially of the American workers.

WILLIAM H. HARRIS, M. D.

PUBLICATIONS RECEIVED.

C. V. Mosby Company, St. Louis: "Examination of Children by Clinical and Laboratory Methods," by Abraham Levinson, B. S., M. D. "Management of the Sick Infant," by Langley Porter, B. S., M. D., M. R. C. S., L. R. C. P. "Principles of Chemistry," by Joseph H. Roe, Ph. D. "Tiger Trails in Southern Asia," by Richard L. Sutton, M. D., Sc.D., LL.D., F. R. S.

Harper & Brothers Publishers New York and London: "Should We Be Vaccinated?" by Bernhard J. Stern.

Williams & Wilkins Company Baltimore: "Medicine Monographs," Vol. XI, Birth Injuries of the Central Nervous System, by Frank R. Ford, Bronson Crothers and Marian C. Putnam.

Year Book Publishers, Chicago: "Practical Medicine Series, General Therapeutics," edited by Bernhard Fantus, M. S., M. D. "Practical Medicine Series, Obstetrics," edited by Joseph B. DeLee, A. M., M. D.

William Wood and Company, New York: "The International Medical Annual, 1927."